

**The Challenges of The HIV and AIDS Pandemic Among Informal
Settlements – A Case Study of Hatcliffe Extension in Harare,
Zimbabwe**

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Definition of Key Terms

AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti-retroviral drugs
ART	Anti-retroviral therapy
CUSE	Condom Use Self Efficacy
CHOGM	Commonwealth Heads of Government Meeting
DAAC	District AIDS Action Committee
FBO	Faith Based Organization
FGD	Focus Group Discussion
GPA	Global Programme on AIDS
HIV	Human Immuno-deficiency Virus
KAPB	Knowledge, Attitude, Practices and Behaviours
MDG	Millennium Development Goals
MoHCW	Ministry of Health and Child Welfare
MTP 1	Medium Term Plan 1
NAC	National AIDS Council
NACP	National AIDS Co-ordination Programme
NGO	Non-Governmental Organization
OVC	Orphans and other Vulnerable Children
PLWHA	People Living With HIV and AIDS
PTCT	Parent to Child Transmission
SIV	Simian Immunodeficiency Virus
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNHABITAT	United Nations Human Settlements Programme
UNHDR	United Nations Human Development Report
UNICEF	United Nations Children's Education Fund
USA	United States of America
VAAC	Village AIDS Action Committee
VCT	Voluntary Counseling and Testing
WAAC	Ward AIDS Action Committee
WHO	World Health Organization
ZAHEC	Zimbabwe AIDS Health Experts Committee
ZHDR	Zimbabwe Human Development Report

Abstract

This research was a descriptive study on the challenges of the HIV and AIDS pandemic in informal (slum) settlements, case studying the Hatcliffe Extension slum in Harare, Zimbabwe. With slums identified as areas of high risk and vulnerability with regards to HIV infection and spread due to high levels of poverty, information gaps existed as to the exact causative factors and transmission dynamics of the pandemic in such areas in the country. This particular study therefore sought to fill in these information gaps as well as to further go on and recommend on how to best address the pandemic in these highly vulnerable communities. More specifically, it sought to determine the factors increasing risk and vulnerability to HIV infection among the informal settlement dwellers, to establish sex networking linkages within and around the settlement as well as to establish the levels of care and support for People Living With HIV and AIDS (PLWHA) and OVC in the settlement. It also had as its other objectives to assess the slum dwellers' knowledge, attitude and practices with regards to HIV and AIDS, establish the factors inhibiting the effective response to HIV and AIDS in the informal settlement and finally to draw lessons and good practices with regards to responding to the HIV and AIDS pandemic in informal settlements.

Data collection included review of project documents of the various development organizations operating in the area, participatory observations, focus group discussions (with grandparents caring for orphans, children heading households, adolescents and adults), key informant interviews with local leadership, government and non-governmental development programmes implementers, as well as in-depth interviews with People Living With HIV and AIDS and orphans. Adolescents and adults were interviewed in-depth in a KAPB survey to establish their knowledge, attitudes, practices and behaviours with regards to sexuality issues.

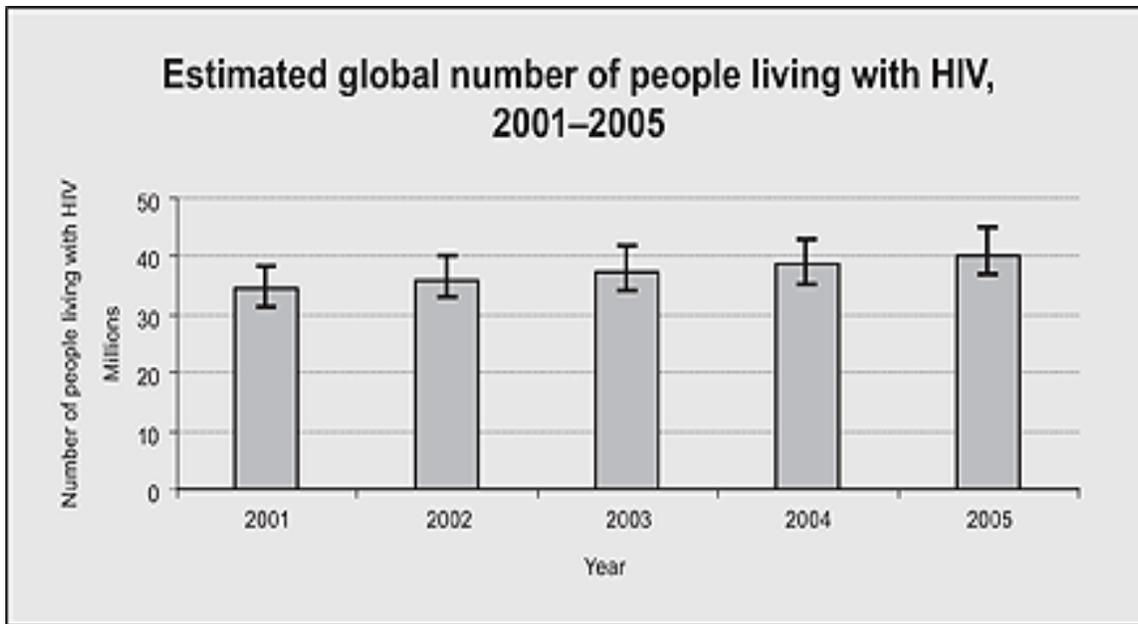
The results clearly showed that poverty and unemployment were the main factors driving HIV infection and spread in the community as people particularly women, engaged in transactional sex as a survival strategy, as affirmed by 62 (60.8%) of the KAPB survey respondents. Poverty also limited care and support for PLWHA as well as orphans. Other factors identified as driving the pandemic in the community were noted as liberal attitude towards sexuality/'loose morals' among the youth (14.7%), child sexual abuse (7.8%), inadequate housing (10.8%) and finally culture-based social re-engineering (5.9%). Challenges towards effective response to the pandemic in Hatcliffe Extension included political interference, donor fatigue to programmes, dependency syndrome of the community as well as lack of coordination in the response strategy itself. Operation Restore Order/*Murambatsvina*, which saw the displacement of people from Hatcliffe Extension, was also noted to have interfered with HIV and AIDS programmes in the area.

The study overall confirmed the interlinkage between HIV and AIDS and poverty informal settlements which was punctuated by gender dynamics, and hence a need was underscored to provide socio-economic empowerment to people in slum settlements, particularly women for response programmes to be effective. Slums were also shown to be a policy blindspot in Zimbabwe, yet a growing reality which could reverse gains made in fighting against HIV and AIDS, because of their high risk nature as well their potential to spread infection into wider society. A need was therefore seen to curb the slum phenomena in the country through rural development, economic growth as well as provision of adequate housing. The effective coordination of the response against HIV and AIDS in informal settlements was also seen as pivotal in attaining real results on the ground, a role which the National AIDS Council needed strengthening in.

CHAPTER 1

1.0 BACKGROUND AND INTRODUCTION

As noted by the joint United Nations programme on HIV and AIDS (UNAIDS) and the World Health Organization (UNAIDS/WHO, 2005:2), HIV and AIDS has since its discovery in 1981 cumulatively taken over 25 million lives, making it one of the worst pandemics in human history. Care USA estimates that more than 14 million children have been orphaned by the pandemic, and the number is expected to more than triple by 2010 (www.careusa.org, 24/11/2005). It is also increasingly becoming an issue of concern that although an estimated 40.3 million adults and children are already living with HIV and AIDS globally (www.globalhealthreporting.org, 28/11/2005), infection rates are soaring despite apparent concerted efforts towards prevention and awareness in many countries, as indicated in fig.1 below (UNAIDS/WHO, 2005:2). The same source indicated that while in 2004 infection rates had become the highest ever since the discovery of the HIV and AIDS scourge, 2005 was even worse and this is obviously a worrying trend for future efforts to fight the pandemic. This is more so when there are reports of increased HIV and AIDS pandemics in all regions of the world over the past two years except for the Caribbean in which the pandemic has remained constant. This does not even indicate that the Caribbean is better than the rest of the world as it is already the second worst affected region globally (HKFF, 2004; UNAIDS/WHO, 2005:2).



Source: UNAIDS/WHO 2005

Fig. 1 Estimated global number of people living with HIV, 2001-2005

1.1 Analyzing Spread of the Pandemic

Care USA (www.careusa.org , 24/11/2005) notes that currently more than 95% of people infected with HIV and AIDS live in the developing world, where there is already existence of scarce financial and material resources to battle the pandemic through awareness, prevention, care and support as well as treatment. The global HIV and AIDS prevalence map for 2005 given below also goes on to illustrate the same point on the spread of the pandemic.

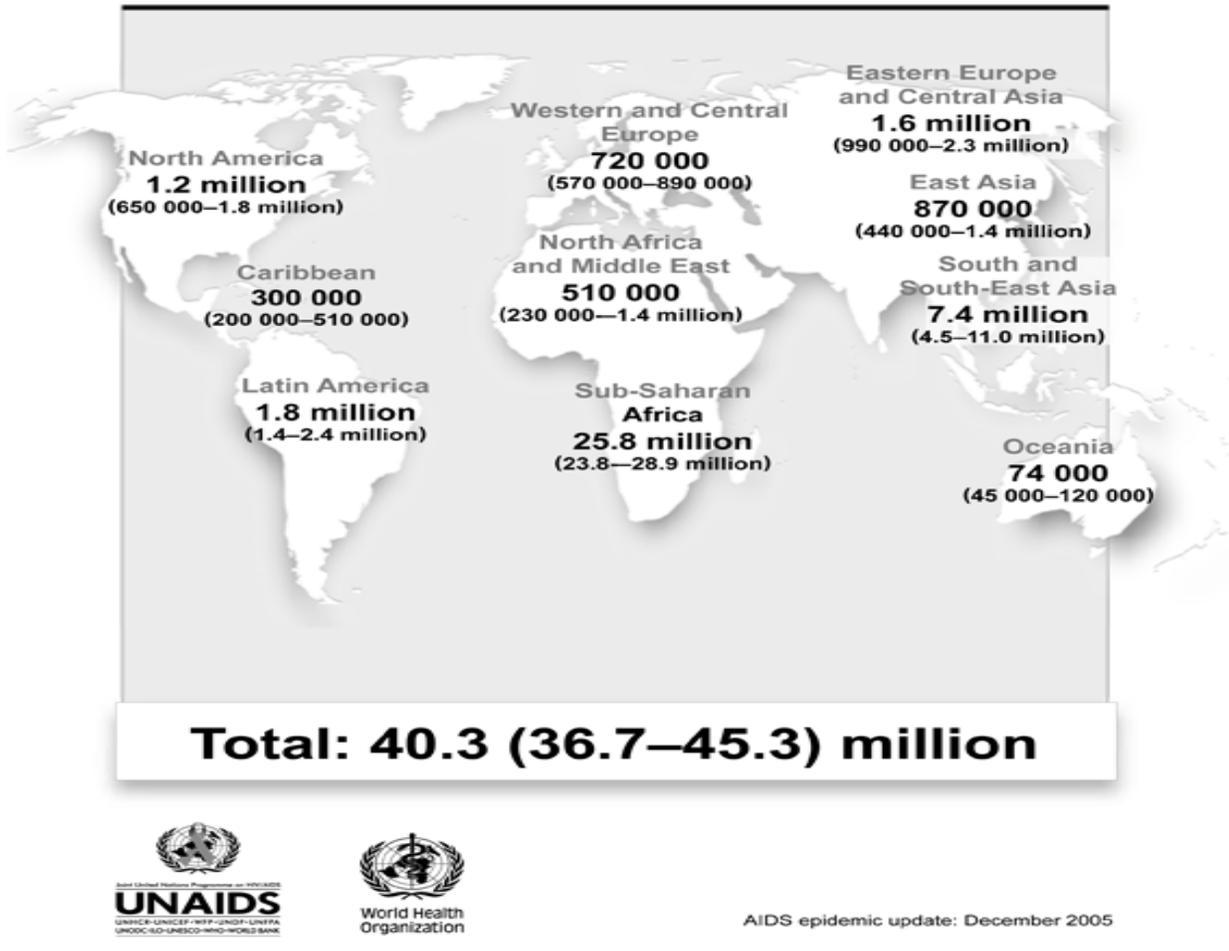


Figure 2: Adults and Children Estimated to be Living With HIV in 2005

However, while openly acknowledging the skewedness of the pandemic towards the developing regions of the world, it should also be noted from the map that Africa apparently appears to be the worst affected. Estimates released by the coalition on Debt, AIDS, Trade and Africa (www.data.org, 30/11/2005) showing that about 6 500 people die of AIDS every day, 9 500 people get new HIV infections and 1 400 babies are infected during birth or by their mothers' milk in the continent also serves to confirm the African HIV and AIDS crisis. Sub-Saharan Africa particularly persists to be the worst hit region on the continent, both as evidenced from the map and basing on what has come out of a number of studies (e.g. Jackson 2002; UNHDR 2003, ZHDR,2003; HKFF,2004; UNAIDS/WHO 2004:19; UNAIDS/WHO

2005). The latter two sources further go on to add that the sub-region has accounted for approximately 75% of global AIDS deaths since 2002, further giving evidence of it being the epicenter of the pandemic in the world .

As studies have shown and has been extensively documented (e.g. UNHDR, 2003; Jackson, 2002; ZHDR, 2003), the pandemic in Sub-Saharan Africa has found fertile ground for spread in poverty that perennially haunts the region. The majority of the countries in the region lie in the low Human Poverty Index range (UNHDR, 2005) and are characterized by high levels of human and income poverty, high probability at birth of not living beyond 40, high illiteracy rates and high unemployment. These factors have without doubt combined to increase risk and vulnerability to HIV and AIDS among the poor (ZHDR, 2003). The same source also notes that the plight of women has been worsened by their socio-economic disempowerment rooted in traditional gender stereotypes. Due to the gender stereotypes, women have been relatively marginalized in terms of higher learning opportunities and consequently economic self-sustainability opportunities. Inevitably women have become more prone to poverty compared to their male counterparts, a scenario known as the feminization of poverty, thereby making the former more susceptible to sexual abuse and violence as they would be depending on their male counterparts for survival.

It is with this recognition that Cohen (1998) noted that unless the poverty situation in Sub-Saharan Africa was addressed, it would be difficult to combat HIV and AIDS. It therefore means that if sustainable long-term mitigation efforts against HIV and AIDS are ever to be ensured in Sub-Saharan Africa, it is imperative for poverty alleviation to be seriously considered as a pivotal component of the overall strategy. Armed conflict has also been attributed to as creating fertile ground for spread of infection in the region. As reported by Dombo *et al* (2001:12), conflict situations come with breakdown in the rule of law,

and so incidences of rape and sexual abuse are high. Cases have also been put across, as noted by the same author, where supposed peace-keepers end up as perpetrators of sexual abuse in refugee camps or engaging in multiple sexual relations since they would be in a financial position to pay for transactional sex. Certain cultural practices have also been noted to be fuelling HIV and AIDS in the region, and a lot of research and documentation has been carried out to this effect (e.g. Runganga, 1991, 2001; Mhloyi, 1990:61-73, Berer and Ray, 1993 among many others). The main areas of concern with regards to cultural practices in the region have been polygyny, widow inheritance, spouse sharing, female genital mutilation as well as certain initiation rites (e.g. as in some cultures in Malawi) in which young women are made to sleep with older men as a form of initiation into womanhood. These are the main causatives that scholars have attributed to the high prevalence rates and worst impacts of HIV and AIDS in the Sub-Saharan Africa region.

1.2 Origins, Debate and Discourse around HIV and AIDS

1.2.1 What exactly is AIDS?

As defined by www.sabin.org (28/10/2005), Acquired Immuno-Deficiency Syndrome (AIDS) is a medical condition caused by the Human Immunodeficiency Virus (HIV) where the immune system cannot function properly and protect the body from disease. As a result, the body cannot defend itself against infections like pneumonia and tuberculosis among many other opportunistic infections. The HIV is spread through direct contact with the blood and body fluids of an infected individual. High-risk activities include unprotected sexual intercourse and intravenous drug use (sharing needles and other sharp objects). Infections could also occur in children at childbirth or in breastfeeding, which is known as mother-to-child transmission.

According to the National Institute of Allergy and Infectious Diseases of the United States of America (www.niaid.nih.gov ; 16/01/2005), untreated HIV disease is characterized by a gradual deterioration of immune function. Most significantly, crucial immune cells called CD4 positive (CD4+) T cells, also known as “T-helper cells” which play a vital role of signaling other immune system cells to perform their special functions are disabled and killed during the typical course of infection. The same source also notes that a healthy, uninfected person usually has 800 to 1,200 CD4+ T cells per cubic millimeter (mm³) of blood. During untreated HIV infection, the number of these cells in a person’s blood progressively declines, a process in which an infected person will not have ill effects and might not even know that they are infected (Dombo *et al*, 2001:10). It is only after the signs of AIDS begin to manifest, when the CD4+ T cell count falls below 200/mm³, that a person becomes particularly vulnerable to opportunistic infections like tuberculosis, pneumonia, meningitis and cancers that typify AIDS, the end stage of HIV disease. People with AIDS often suffer infections of the lungs, intestinal tract, brain, eyes, and other organs, as well as debilitating weight loss, diarrhea, neurological conditions, and cancers such as Kaposi’s sarcoma and certain types of lymphomas (www.niaid.nih.gov ; 16/01/2005; Jackson, 2002, Lowenson & Whiteside, 1997)

HIV and AIDS is without doubt a fatal disease apparently with no cure and no vaccine to prevent its spread. Even world-renowned scientist and co-discoverer of HIV, Professor Robert Gallo, speaking at the 2005 International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA), acceded to the reality that despite all the efforts being put in research, chances of a landmark discovery with regards to an AIDS vaccine were still theoretical (Haruna and Taiwo, 2005). As emphasized by many authors (see www.who.int , 09/09/2005; WHO/UNAIDS,2005 ; Dombo *et al* ,2001 ; Jackson 2002; ZHDR,2003 etc) the best medical science can offer, at least for now, are drug therapies (Anti-Retroviral Therapy) which slow down replication and hence weakening of the body’s immune system by the HIV

thereby building resistance to opportunistic infections. Devising a vaccine or cure against AIDS continues to be hampered by the fact that the HIV is highly mutant and so rapidly adapts to changing conditions, as underlined by Dombo *et al* (2001) and Jackson (2002) among other authors.

It is indeed undisputable that the HIV and AIDS pandemic has wrecked havoc on humankind in the past two decades the world over, as evidence above shows. While in the process of getting to understand the global impacts and consequences of the HIV and AIDS pandemic however, it would also be crucial to have an appreciation of the origins of this pandemic and how it has grown to be so potent. The next section therefore focuses on the historical perspective of the pandemic up to where we find it in this era.

1.2.2 The debate on origins of HIV and AIDS

The discovery of HIV

Initially called GRID or Gay-Related Immune Deficiency Syndrome, AIDS had been identified in gay men in the US in 1980/81. In 1983, Louis Montaigner and his team at the Pasteur Institute in Paris identified HIV. A year later Robert Gallo and his team in the US cultivated the virus, leading to a long drawn-out wrangle over attribution. Later HIV was found to have two main sub-types, HIV-1 and HIV-2, HIV-2 occurring mainly in West Africa and to a much less extent elsewhere, and HIV-1 spreading much more extensively around the globe. HIV-1 in particular has numerous variants, but both viruses mutate, or change in the body over time. Like HIV-1, HIV-2 also leads to AIDS, but apparently more slowly, and it appears less easily passed through sex.

Adapted from Jackson (2002:2)

While there seems to be general agreement as to when the Human Immuno-deficiency Virus (HIV) was discovered, a lot of interesting debate has been raised with regards to its origins and despite the extensive research done on the subject, that question still remains unanswered (Whiteside and Sunter, 2000:3). Research has shown that the HIV is closely related to simian (monkey) immunodeficiency viruses (SIV),

as noted by Jackson (2002:5), and so could have originated from there. The question asked then would be how such class of viruses could have been passed on to humans. While some argument has been raised as to whether HIV, and subsequently AIDS is not a form of punishment from God for sexual promiscuity, according to the same author, many authors have countered each other's debates on the actual origins of the Human Immuno-deficiency Virus.

While Whiteside and Sunter (2000) dispel the school of thought that the virus could have been man-made or from outer space, authors like Ed Hooper (2001:1-2) and Horowitz *et al* (1996) indeed attest to their theories that the virus being man-made, either by intent or just experiments gone wrong as people were being vaccinated against polio and hepatitis B respectively. Jackson (2002:5) however comes back to argue that research has not given any validity to the Hooper theory and instead proposes that the SIVs, which subsequently mutated into HIV could have been transmitted to human beings through cuts and bites as people hunted down monkeys and chimpanzees for food and for keeping them as pets. Other authors like Weiss (2001: 947-953) as well as Burr *et al* (2001: 877-887) also come in with arguments to counter Horowitz *et al* and the arguments have raged on. While the debates on the origins of HIV were going on, another school of thought emerged to the effect that HIV actually was not in existence, as elaborated in the section below.

1.2.3 The Dissident View

Indeed while arguments went on about the origins of HIV and AIDS, as shown above, a certain group of molecular biologists and virologists, the so-called “dissidents” were putting up a debate on whether HIV actually caused AIDS (www.virusmyth.net, 15/10/2004). Propelling a view that even President Thabo Mbeki of South Africa bought into, the scientists were variably arguing that:

- HIV did not exist, or if it did, it was harmless and could not cause AIDS
- HIV was harmless on its own, but could lead to AIDS in the presence of other health stressors like malnutrition, poverty, use of drugs and the presence of other infections (www.virusmyth.net, 15/10/2004; www.deusberg.com ,19/01/2005 ; Odipo,2001; Whiteside and Sunter,2000)

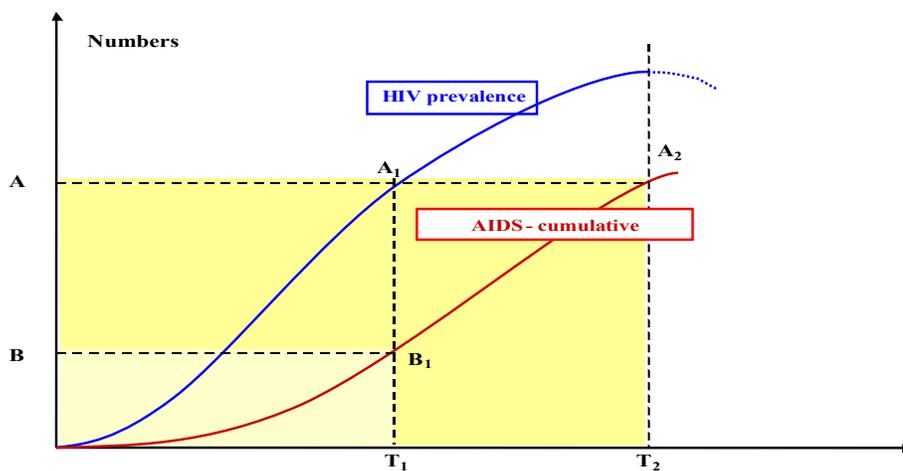
However many respondents to this dissident view have gone on to give concise scientific proof into the existence of HIV as well as its apparent link to AIDS, and this evidence has been widely published by the National Institute of Health in the USA (www.niaid.nih.gov ,16/01/2005 ;**see also** Jackson, 2002:5-6).

While all these arguments could have been put across from various facets and for various reasons, evidence consistently shown by the World Health Organization, UNAIDS and the Global Human Development Reports based on country reporting processes show that the HIV and AIDS pandemic is existent globally and its impacts are being felt at all levels of social and economic development (www.un.org , 04/01/2005).

1.3 Why Such Concern about HIV and AIDS?

A question would then be asked about why all this concern on the HIV and AIDS pandemic as if there have not been or continue to be any other epidemics in the world. In the past, epidemics like the Plague¹ that wrecked serious havoc in Europe around the 15th Century (<http://uhavax.hartford.edu> , 20/09/2005) have occurred and presently diseases such as cholera and malaria continue to cause epidemics of health concern worldwide, what then is it about the HIV and AIDS epidemic? The answer lies in the brief explanation of the disease's epidemiology, illustrated firstly by a graph of the HIV and AIDS curves, as given below.

1.3.1 Epidemiology of HIV and AIDS



Source Whiteside and Sunter (2000:27)

Figure 3: HIV and AIDS Epidemic Curves

¹ The Plague (bubonic and septicemic) involved hemorrhagic illness (bleeding), multiple system failure and death. All of this would occur within three to seven days. The mortality rate for untreated bubonic Plague was about 50-75% and 100% for septicemic Plague.

While the HIV and AIDS pandemic follows the sigmoid (S-shape) curve typical of other epidemics, the graph above gives evidence to its peculiarity. Unlike other epidemics, for example the Plague in Europe which claimed a lot of lives in short periods of time around the 15th century (<http://uhavax.hartford.edu>, 20/09/2005), HIV and AIDS has two curves, the HIV curve and the AIDS curve and they are separated by anything between 5-10 years (Whiteside and Sunter, 2000:27). From the graph above, it can be seen that at a given point in time (e.g. T_1 on the graph), a large number of people can be infected by HIV and only a little show signs of ill health (B_1). By the time a significant number of people begin to show signs of ill health (T_2) even higher numbers would have joined the infection pool and the impacts would then begin to manifest through high rates of morbidity and mortality. It implies then that unlike other epidemics where a large number of people is infected over a short period of time and authorities immediately engage on high alert to control the epidemic, by the time AIDS begins to manifest itself in deaths and illnesses, a lot of new infections and extensive demise of human capital would have already occurred and so even being on 'high alert' at this juncture will not necessarily contain the pandemic. Another difference between HIV and AIDS and such epidemics as the Plague, as pointed out by Jackson (2002:1) is that while the Plague was wiping out people of all ages, whether young, the elderly, the weak and the infirm with compromised immune systems, HIV and AIDS on the other hand affects mainly the most economically productive and reproductive age groups (15-49 years age group, according to the same author) because of the predominantly sexual mode of its transmission. This without doubt compromises various facets of social and economic development as such in the age group that national and household economies depend on. As asserted by Dombo *et al* (2001:20), HIV and AIDS clearly negatively impacts on essential human capital formation, and therefore poses development threats at all levels of socio-economic and political fabric. Economies were shown to be suffering due to high mortality and morbidity of the human resource base, life expectancy was diminishing and cycles of poverty were becoming more complex as the too young and

too old were being left without the capacity to sustain economies at both household and national levels in many countries. It was then clear that a developmental dilemma was on its way from what could have been perceived as yet another typical biomedical problem requiring a biomedical solution.

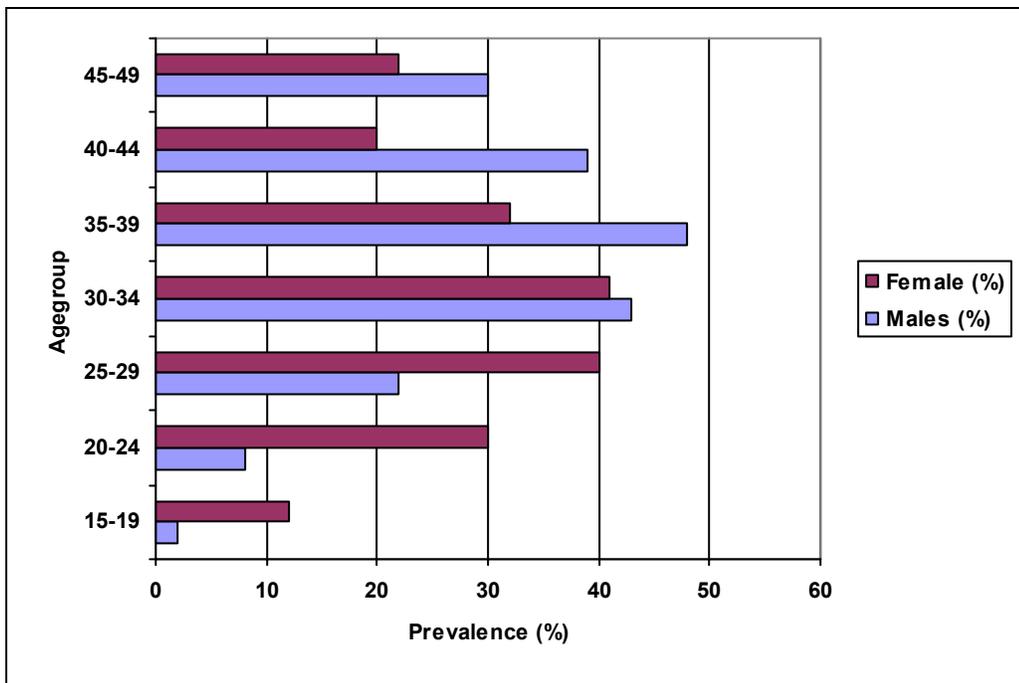
1.4 The Global Response to the HIV and AIDS Pandemic

Although the global response to the pandemic was initially characterized by denial and complacency that the pandemic could easily be contained like all other epidemics in the past (ZHDR, 2003:121), it was not until 1987 that the World Health Organization (WHO), health arm of the United Nations began responding to the reality that the pandemic was indeed a global crisis and devastating lives in many countries of the world (Merson, 2005). The Global Programme on AIDS (GPA) was then formed under the WHO and is reported to have successfully mobilized national responses, initiated much needed research and so became a voice for those living with AIDS, according to the same author. While there would certainly be no question with regards to the importance and relevance of a WHO-driven response process to the pandemic, there was still necessity to have a more multi-sectoral response framework based not just on a narrow biomedical approach, but one looking essentially at the developmental perspective of the pandemic. The ushering in of the Joint UN Programme on AIDS (UNAIDS) in 1996 from the GPA to coordinate AIDS-targeted programming across the United Nations system (including World Bank) was therefore a welcome move towards a multisectoral response framework against the pandemic. Subsequent mobilizations around the HIV and AIDS pandemic then began to be informed by the need for development-oriented response strategies and with the coming of the new millennium, HIV and AIDS combating was considered a key result area in terms of sustainable eradication of human poverty and suffering as pointed out in the Millennium Declaration of September 2000 (UNHDR, 2003:8). Of the eight Millennium Development Goals (MDGs) emanating from the Millennium Declaration set on eradicating

extreme hunger and poverty, ensuring universal access to education, health care, gender equality, the combating of major diseases as well as building global partnerships in development, the goal to combat and reverse the effects HIV and AIDS was put on Goal 6. This was in recognition of the pandemic's capability to undermine progress achieved towards attainment of the other goals, as pointed out by the ZHDR (2003:2). The 2001 UN General Assembly Special Summit on HIV and AIDS also confirmed the imperatives of mitigating and combating the developmental impacts of HIV and AIDS because of the potential it had to reverse gains in other human development indicators. At this point, response frameworks globally are being guided by various declarations and commitments that heads of states and governments have signed at national, regional and international levels in acknowledgement of the need for a multi-sectoral development-based response strategy to the HIV and AIDS pandemic.

1.5 The HIV and AIDS Pandemic in Zimbabwe

Zimbabwe, being in the region which is without doubt the epicenter of the HIV and AIDS, has also not been spared by the pandemic, with the National AIDS Council (2004:7) estimating that on average, 2500 people die as a result of the disease every week in the country. UNICEF (www.unicef.org 15/01/2006), points out that due to the pandemic, the average life expectancy in the country has fallen from 61 to 33 years. The approximations released by the Ministry of Health and Child Welfare (2005) indicate that about 1.6 million people are presently living with HIV in the country, annual AIDS deaths stood at 186.140 (21.4% being children) and 180.600 (2.4% being children) new infections occurred by the end of 2005, according to the same source. A careful analysis of the pandemic in the country by the MoHCW in 2003 showed that women and girls particularly those in the 15-29 year age range were disproportionately most vulnerable to infection compared to other age groups (NAC, 2004:7) as shown in the graph below



Source: Zimbabwe National HIV and AIDS Estimates, 2003

Figure 4: Prevalence Rates by Age and Gender in Zimbabwe

The Government of Zimbabwe (2004:23) attributed high prevalence of other sexually transmitted infections, low levels of male circumcision, multiple sexual partner-relationships, traditionally low, incorrect and inconsistent use of condoms, mobility of partners as well as poverty and low socio-economic status of women as the main factors contributing to the spread of HIV and AIDS in the country. It is also another issue of concern how the pandemic in the country has left a legacy of orphanhood, rates which UNICEF (www.unicef.org 02/11/2005) estimate to be around 75% of the total number of 1.3 million orphans. While the Government of Zimbabwe (GoZ) has attested that the HIV prevalence rates have fallen from 24.6% in 2001 to 20.1% in 2005 (MoHCW, 2005), such fact of diminishing trends which was

confirmed by the UNAIDS/WHO Epidemic Update of 2005, the latter report also went on to mention that the rate was still very high and a sustained maintenance of the decline still needed to be ensured.

After diagnosis of the first case of HIV in 1985, the GoZ responded the following year by setting up the Zimbabwe AIDS Health Experts Committee (ZAHEC) as an initial response strategy. With the support of the United Nations Country Team, the government then created the National AIDS Coordination Programme (NACP) in 1987 under the Ministry of Health and Child Welfare to mobilize human, technical and financial resources to spearhead the mitigation and prevention activities against the HIV and AIDS pandemic. The year 1988 saw the announcement of a 5 year Medium Term Plan (MTP1), which then paved the way for the MTP1 from 1994-1998 (UNDP, 2006:13).

The NACP made significant progress in awareness building on HIV and AIDS and it is under its umbrella that the National HIV and AIDS Policy and Strategic Framework for National Response to HIV and AIDS for the years 2000-2004 were compiled. The main focus in the Strategic Framework was on the employment of broad-based participatory consultative processes drawing attention to the epidemiological and socio-cultural drivers of the pandemic. Upon the realization however that HIV and AIDS was increasingly becoming more of a developmental concern other than just a health problem, the NACP was transformed into the National AIDS Council (NAC) through an Act of Parliament in 1999 (National AIDS Council Act: Chapter 14, 15 of 1999), as was noted by UNDP (2006:14). It became operational during the year 2000 after the establishment of a national secretariat and provincial co-ordination offices as well as decentralized District AIDS Action Committees (DAACs), Ward AIDS Action Committees (WAACs) and Village AIDS Action Committees (VAACs) and principally its role was to act as the coordination vehicle for the HIV and AIDS response nationally, within the various legislative, policy and strategic

mechanisms established by the Government of Zimbabwe. The NAC was legislatively mandated to raise funds through the National AIDS Levy, using three percent (3%) payroll income tax which contributed to the National AIDS Trust Fund, the money which NAC manages and disburses for implementation of various strategic responses in the fight against HIV and AIDS (ZHDR, 2003:130-131).

The establishment of the National AIDS Council together with the Government's willingness to engage other stakeholders from the civil society and private sector in the fight against HIV and AIDS saw the beginning of the multisectoral response to the pandemic in the country. In May 2002, HIV and AIDS was declared as a national disaster by the Government and this laid the foundation for resource mobilization for the fight against the pandemic (ZHDR, 2003:141). Various fora were then established for purposes of strategically responding to the disaster. A Care and Treatment Forum under the co-ordination of the Ministry of Health was set up specifically for the scaling up of Anti-Retroviral Treatment (ART). The Ministry of Public Service, Labour and Social Welfare was tasked to coordinate the forum for Orphans and other Vulnerable Children (OVC). A partnership forum for HIV and AIDS was also established in 2003 under NAC with the main purpose of bringing together various actors for strategy formulation as well as for co-ordination of the response to the pandemic (UNDP, 2006:15).

Apart from the above actions towards a multi-sectoral response strategy to the pandemic, the GoZ has also demonstrated some commitment through the acceptance of the Declaration of Commitment of the United Nations General Assembly Special Session on HIV and AIDS, UNGASS of June 2001 as well as in adoption of the Maseru/SADC Declaration on HIV and AIDS of July 2003². The government also prioritized MDG 6 on combating HIV and AIDS, MDGs 1 and 3 on poverty and gender respectively,

² The Maseru/SADC Declaration on HIV and AIDS endorsed and adopted the implementation of the SADC Strategic Framework on HIV and AIDS

thereby openly acknowledging the need for gender- equitable poverty alleviation and combating of HIV and AIDS to ensure that gains in other fronts of human development were not undermined (GoZ MDGs Progress Report , 2004:12) .

1.6 Statement of the Problem

While it is commendable that HIV prevalence rates are showing signs of declining in Zimbabwe, as given in section 1.5 above, the apparent challenge is obviously to maintain such a decline. However the current realities present a complex situation in which due to the unfavorable macro-economic situation, human and income poverty (which are strongly interlinked with increased risk of HIV spread) are on the rise (see Tibaijuka,2005; CCZ, 2005), yet there is a need to keep factors enhancing spread of HIV and AIDS at minimum (Cohen,1998). It therefore becomes imperative to consistently check on areas of highest vulnerability to HIV infection and make attempts to contain spread because such areas might become points from which infection spreads to wider areas in the country through sex networking, in the process undermining gains made in the fight against the pandemic already. Informal settlements are critical examples of such areas as they are endowed with high levels of concentric poverty and relative isolation in terms of socio-economic amenities. It then goes without saying that these informal settlements are pockets of high risk to HIV infection and spread and therefore should be policy priorities among other high-risk areas in terms of response to the pandemic. Particularly so in the Zimbabwean case, where slum settlements are in peri-urban areas of commercial farming and mining activities (areas of which were noted to have the highest HIV prevalence rates – ZHDR, 2003:52), there is certainly a need to contain HIV infection as well as spread in such settlements. Unfortunately, there are knowledge and information gaps on the plight of informal settlements with respect to the pandemic in Zimbabwe, subsequently making informed policy direction with regards to effective response strategies in such areas difficult.

This particular study of the Hatcliffe Extension informal settlement therefore hoped to fill in such information gaps. Lessons learnt from the study could then inform local, national, regional and even international policy concerning how to deal with HIV and AIDS in high-risk communities, particularly informal settlements. In order to attain such ends therefore, the study was premised on the research questions and objectives in the two sections below.

1.7 Research Questions.

- What are the main developmental and health problems being faced by people in the Hatcliffe Extension informal settlement?
- How has HIV and AIDS impacted on the settlement?
- What challenges are being faced by orphans and other vulnerable children (OVC) in the Hatcliffe Extension informal settlement?
- What influences people's attitude, practice and behaviour towards sex and HIV and AIDS in the community?
- What are the main sources of risk and vulnerability to infection in such communities?
- What sex networks exist in the Hatcliffe Extension community and what propagates them?
- What response strategies have been put in place by various partners working in the informal settlement and what have been their challenges?
- What lessons can be learnt from the Hatcliffe Extension case with regards to good practices in dealing with HIV and AIDS in slum settlements which can then be replicated in other similar settings?

1.8 Objectives of the Study

1.8.1 General Objective

The study overallly sought to establish the impacts of HIV and AIDS on the Hatcliffe Extension informal settlement as well as to explore the various social, economic and policy-related factors presenting challenges in addressing the pandemic in the slum settlement.

1.8.2 Specific Objectives

1. To determine the factors increasing risk and vulnerability to HIV infection among the informal settlement dwellers.
2. To establish sex networking linkages within and around the Hatcliffe Extension informal settlement.
3. To establish the levels of care and support for People Living With HIV and AIDS (PLWHA) as well as Orphans and other Vulnerable Children (OVC) in the settlement.
4. To assess the slum dwellers' knowledge, attitude and practices with regards to HIV and AIDS.
5. To establish the factors inhibiting the effective response to HIV and AIDS in the informal settlement.
6. To draw lessons and good practices with regards to responding to the HIV and AIDS pandemic in informal settlements.

CHAPTER 2

2.0 REVIEW OF LITERATURE AND THE CONCEPTUAL FRAMEWORK

2.0.1 Introduction

Chapter One was basically reviewing the background and introduction to the HIV and AIDS phenomenon, what it is, its origins and debates as well as the global, regional and local levels in Zimbabwe. It then went further to confirm the nexus between spread of the pandemic and high levels of chronic poverty, hence problematizing the high risk of infection and spread of the disease in areas like informal (slum) settlements, the focus of this study. Now this chapter explores the work by numerous authors on the whole concept of the slum phenomenon, how slums have built up globally over the time and what factors actually make such settlements areas of great risk and vulnerability to the HIV and AIDS pandemic. From linking such factors, this chapter then arrives at the rationale for the study making reference to and supported by a theoretical basis from literature. Finally, the chapter concludes with the establishment of a conceptual framework subsequently informing the overall study.

2.1 The Slum Phenomenon

Informal settlements are generically known as ‘slums’ by human settlements standards and the United Nations Human Settlements Programme (UN-HABITAT, 2003:12) defines slum areas as those places characterized by one or more of insecurity of tenure, poor structural housing conditions, deficient access to drinking water and sanitation as well as severe overcrowding. The occurrence of such settlements has tremendously risen globally in the 21st Century, with a third of the estimated three billion urban dwellers living in slums, as noted by the same source. Sclar *et al* (2005:901-03) point out that slums certainly do not occur overnight and they are historically rooted in rapid urbanization which has spanned for well over 250 years. These authors further say that rapid urbanization began in countries undergoing

industrialization in the developed world, then followed by Latin America and now the current locus is in poorer parts of Asia as well as Africa. As pointed out by the Lancet Magazine (www.thelancet.com , 30/04/2005), in the background of increased projections in rural-urban migration, it is anticipated that by 2030, close to 1.7 billion of the expected 3.93 billion urban dwellers will be living in slums, unless substantial policy changes would be put in place.

2.2 Development of Slums in Africa

The proliferation of slums in Africa was mainly attributed by UN-HABITAT (1993) to increased population sizes, decreasing per capita income, rapid urbanization, political and war-based displacement as well as failure by planning authorities to provide adequate housing infrastructure. This particular challenge of slums apparently seems to be getting worse, as noted by Auclair, (2005). The author noted that between 1990 and 2001, African urban slums populations increased by about 65 million, an average of 4.5% per annum and approximately 2% more than total population growth. Without appropriate policy response, the same author predicts that slum populations would double on average every 15 years to an estimated 322 million by 2015. The UN Chronicle (2003) also highlights how sub-Saharan Africa has the highest proportion of slum dwellers, with 166 million out of a total urban population of 231 million classified as slum dwellers (a proportion of 71.9%). This figure of slum dwellers comes second just after South-central Asia, which has about 262 million people living in slum settlements.

2.3 The Zimbabwean Case

While forces of rapid urbanization also created glaring gaps between supply and demand for housing in Zimbabwean cities (one of which this study was based), Tibaijuka (2005:25) noted that the country's cities were relatively unaffected by the explosive proliferation of slum settlements typical of other African cities. In a scenario described as unique by the author, statistics by UNHABITAT (2003) noted that in 2001 only 3.4% of the urban dwellers in the country were recorded as slum dwellers, much lower than the 6.2% estimate of urban slum dwellers in industrialized nations. Tibaijuka (2005:25) explained this scenario by saying that the country had succeeded in enforcing stringent building by-laws and standards which prevented putting up of sub-standard shelters as well as the lack of access to public land since most of the land surrounding cities was privately-owned farms. However, the advent of the land reform exercise saw the occupation of peri-urban farms and this as the author put it, provided the opportunity for the urban poor to occupy land in the vicinity of the cities, thereby creating slum pockets. The more established slums like Hatcliffe Extension and Dzivarasekwa Extension had been created as temporary holding camps in the early 90s for displaced homeless people while government sought more permanent housing for them (Manyati, 2004:10-11)

2.4 Slum Settlements, Poverty and HIV and AIDS

Haque (2003) and Tibaijuka (2005:22-23) asserted that poverty, unemployment as well as the need to look for better life prospects were the main factors fanning rural-urban migration. However, in most cases as Haque (2003) puts it across, the majority of these migrants would be illiterate or partially literate and would not have any expertise that would allow them decent employment.

Imminently, slum communities would therefore comprise of poverty-stricken unemployed people who could not afford both basic food and non-food essentials. The United Nations Human Settlements Programme (UNHABITAT) in 2003 asserted the nexus between the mushrooming of slums in urban areas and poverty, and both were said to be often mutually reinforcing. While there would be a few people within slum settlements with reasonably high incomes to afford alternative as well as better housing and living conditions elsewhere, the majority would rely on being cheap labourers, general hands, engaging in crime, selling of drugs and for the women predominantly the commodification of sex as survival strategies (<http://topics.developmentgateway.org;08/10/2005>; Haque,2003; Winton, 2004:165-84; www.kambevvet.org, 23/03/2006).

Women were also noted by Winton (2004:165-84) to be at the risk of sexual violence, rape, and even in cases of consensual sex less inclined towards condom use due to various socio-economic disempowerment factors which would make it difficult for them to negotiate for safer sex, as established also by Fernandes *et al* (1994) in a study of four slums in Brazil. In a study of sexual behaviour in a slum in Bangladesh, Haque (2003) also established rampant sex networking amongst sexually active people within slum settlements. Poverty has been shown as the main driver of risky sexual behaviour in slum settlements, as confirmed by, *inter alia*, studies by Jagha and Adedimeji (2002) which focused on sexuality amongst young adults in a slum in Nigeria as well as studies in Indian slums (www.IndianNGOs.com, 29/01/2006). Poverty-related factors were also shown to be the main drivers of risky sexual behaviours in Kenya, as noted by Auclair (2005). The few pockets of relatively high income in the settlements would certainly be targets for commercial sex as they would be able to pay for it; hence they would form the entry points into the complex web of sexual activity typical of the slum settlements.

As was also noted by Sclar *et al* (2005:901), communicable diseases are a major problem in slum settlements, among them including tuberculosis, acute respiratory infections, meningitis, diarrhoeal diseases as well as worm infections. Inadequate drainage also poses dangers of breeding of mosquitoes, increasing the risk of malaria infection. The same authors also pointed out that transmission of the various illnesses would be aided by low resistance due to malnutrition. It would therefore mean that tackling HIV and AIDS from the treatment dimension would be extremely difficult because of the high prevalence of opportunistic infections, especially considering the inaccess to quality health care of slum dwellers.

The National Academy of Sciences (2003) established in community-based studies that the harsh physical and social conditions of urban slum life led to chronic stress and depression among adults dwelling in such settlements. The psychological implications of slum dwelling amid high poverty levels and conditions falling below humane standards was also confirmed by Warah (2003) and Haque (2003), the latter who concluded the levels of desperation, fatalism and hopelessness in such settlements led to risky health and sexual behaviour including alcohol and drug abuse as well as multiple-partner sexual relationships.

It is without doubt that a realization has been made globally to address the phenomena of slums, as evidenced by the UN Millennium Declaration which set targets in the MDG 7 to improve the lives of at least 100 million slum dwellers by 2020 (UNHDR, 2003:123). However, UNHABITAT (2003) notes with concern what it termed the general apathy and lack of political will among Governments to implement policies aimed at improving conditions in slum settlements. In the same report, the agency also elaborates that slum formation is inter-related to economic cycles, trends in national income distribution as well as national economic development policies.

Failure of these policies has therefore had a resultant weakening effect on capacity of governments to respond to the urban housing crises and further impoverishment of ordinary people. For as long as policy fails to address macro-economic fundamentals and alleviation of human and income poverty, it would be difficult, not only to alleviate suffering of slum dwellers, but also to contain the HIV and AIDS pandemic which is driven by these factors.

2.5 Rationale of the Study

Given this kind of context and the overall acknowledgement that poverty is the main driver of the HIV and AIDS pandemic in slum settlements, the study would therefore wish to descriptively interrogate the dynamics of infection and spread of the disease in the Hatcliffe Extension slum. Beyond just the socio-economic factors leading to high risk and vulnerability, the study further intends to explore socio-cultural as well as psychological drivers of the pandemic as well. As noted in this review, studies done in informal settlements mainly centered on psychological challenges of stress and depression among adults in these areas. This study however also goes further to assess the same dimensions in OVCs *vis a vis* the HIV and AIDS pandemic because, as mentioned by Sokolova (2003), suboptimal early developmental experiences, and exposure to stressful life conditions as those found in slums, orphanhood as well as the psychological effects of being infected or affected by HIV and AIDS would also tend to cause depression in children.

2.6 Theoretical Framework

As an entry point into the theoretical basis for this study, an analysis is made on the theory of Culture of Poverty. This theory was developed by Oscar Lewis in 1959 and was based on his experience of Mexico. It states that the culture of poverty is a specific syndrome that proliferates in situations where there is a high rate of unemployment and under employment, low wages and people with low skills, as typical in informal settlements (Islam, 2005:2-3). The poor realize that they have a marginal position within a highly stratified and individualistic capitalistic society, which does not offer them any prospect for upward mobility. In order to survive they would then have to develop their own institutions and agencies because the larger society tends to ignore and bypass them. Thus the poor come to embody a common set of values, norms and pattern of behaviour, which is different from the general culture as such. In short, the poor would then have their own way of life – a specific subculture. In his classification of the traits underlying this sub-culture, Lewis spoke of the nature of the slum community; characterized by poor housing and overcrowding, as well as minimum organizational structure beyond the space of family. He also spoke of how the slum communities were inward looking and relatively closed communities. The theory also argues of how individuals in the culture of poverty have ‘a strong feeling of fatalism, helplessness, dependence and inferiority’; a weak ego tuned to the gratification in the present and a strong preoccupation with masculinity. Once the subculture is formed it tends to be perpetuated. It is transmitted from one generation to another through socialization. It goes without doubt that such a scenario as exists in slum settlements would create conducive ground for ‘silent’ high HIV infection and transmission rates that could go un-noticed at policy and response levels for a long time.

The tendency towards being hopeless, inferior, dependent as well as lowly self-esteemed, typical of people in the culture of poverty as described by Oscar Lewis would also mean that even the building of

community groupings and social networks towards finding solutions to community problems would be made difficult. This would obviously be quite unfortunate with respect to HIV and AIDS, without doubt a community problem requiring collective community efforts to cope with. This premise is further supported by Social Capital theory, which argues that people act together more effectively to pursue common objectives through social networks, norms and trust. It further explains that social capital is operationalized through socio-cultural (degree of interaction within members of a social circle) as well as institutional infrastructure i.e. the presence of community organizations and their ability to act on behalf of the community (Lin, 2001:278). It then means that programmes relating to HIV and AIDS that strengthen social capital would have better sustainability than ones leaving out such principle.

The strong preoccupation with masculinity is also given mention of in the Culture of Poverty theory and in studying slum settlements where poverty is typically an inter-generational culture, it would be essential to take note of the Theory of Gender and Power. This theory looks at the broader social and environmental issues relating to women, including gender relations, societal definitions of masculinity and femininity, and economic power. It argues that self-protection and socio-economic empowerment of women is often swayed by gender relations, societal definitions of masculinity and femininity, as well as the socialization of women towards sexual subservience and passiveness (Wingood and Di Clemente, 2000:539-565). Such theoretical basis would obviously be important in understanding the causal factors enhancing vulnerability of women to HIV infection, as noted by Kiragu and Pulerwitz (1999)

This study therefore was premised on a pluralist approach with regards to its theoretical basis, with the theory of Culture of Poverty as the main theory. The others supporting this major theory were the Social Capital Theory as well as the Theory of Gender and Power.

2.7 Conceptual Framework

Basing on the various theoretical arguments and literature reviewed in this study, a conceptual framework was then developed and is presented diagrammatically as below:

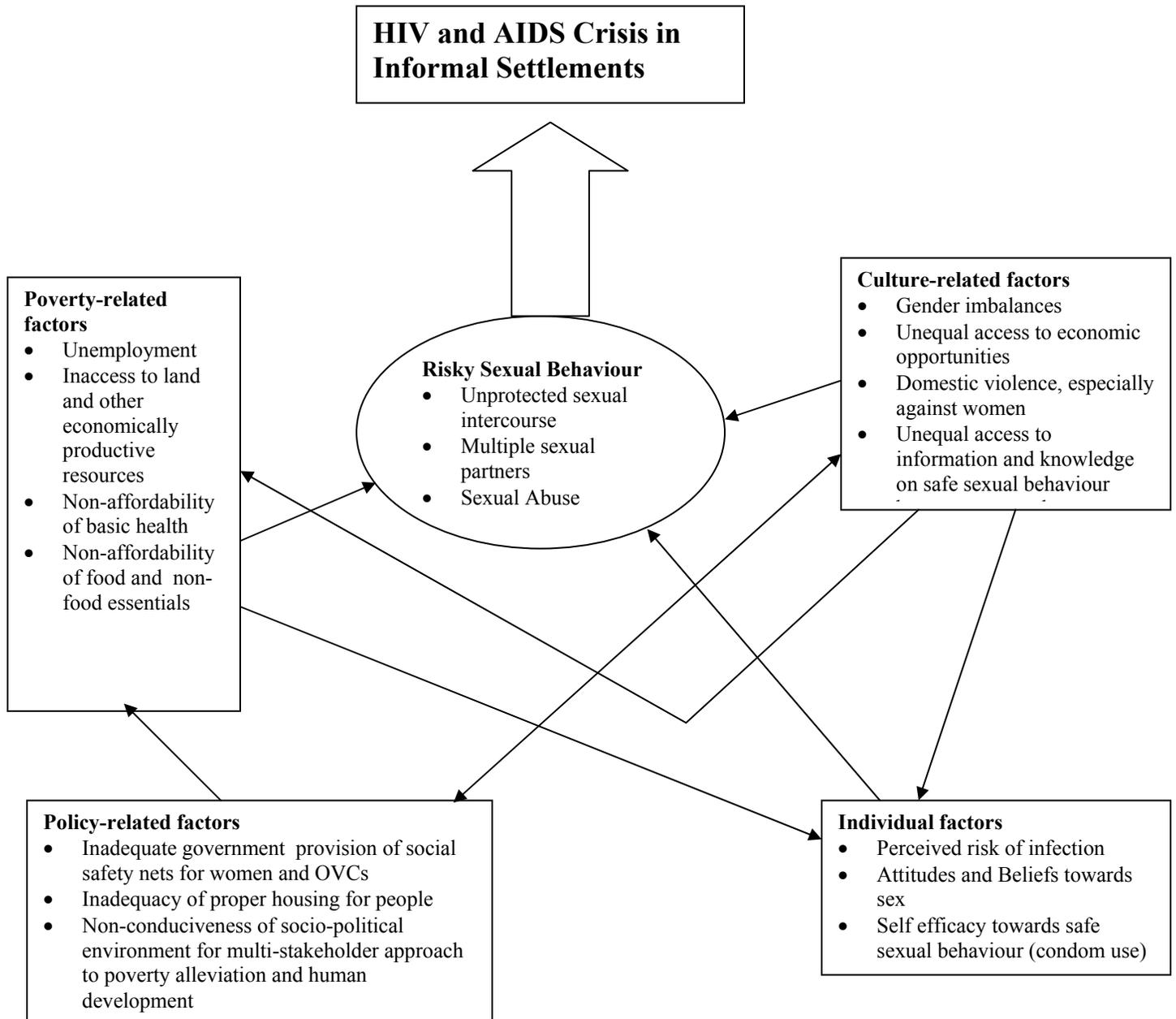


Figure 5: Study Conceptual Framework

CHAPTER 3

3.0 STUDY CONTEXT, DESIGN AND METHODOLOGY

3.0.1 Introduction

Following the establishment of the conceptual framework this study would be based on in the previous chapter, Chapter Three goes further to look at the study context, the research design as well as the methodology the research was carried out using. In order to bring out a clear understanding with regards to the context of the study, the chapter begins with a historical background and characteristics of the Hatcliffe Extension, the study area. The research design is then laid out; thereafter the various aspects of the methodology looked into, including data collection methods, analysis techniques as well as the ethical considerations and limitations to the study.

3.1 Study Area Historical Background

The Hatcliffe Extension informal settlement came up as a culmination of ‘clean-up exercises’ by the Government of Zimbabwe. The first one was carried out ahead of the visit by the British monarch, Queen Elizabeth II to open a Commonwealth Heads of Government Meeting (CHOGM) hosted by the country in 1991. People living on the streets among them the destitute, among them ex-farm workers of foreign origin who had lost their jobs and had nowhere to go as well people living in shanties in the capital Harare’s high-density suburbs were rounded up and relocated to Porta Farm, about 25km west of the capital (IRIN, 2004 www.irinnews.org ; 20/11/2004). Some of the displaced people moved to another nearby farm called Churu Farm. Actionaid (2005) noted that after the government had once again moved people from Churu Farm in 1993, some were then moved to Hatcliffe Extension, about 30km north of

Harare ,supposedly as another temporary measure as government sought for more substantive resettlement options for the people (Stevenson,2005) .

The peri-urban settlement, estimated by Manyati (2005) to have a population in the excess of 2300 people, with approximately 45% being adults and the rest children, was situated near Hatcliffe high density suburb as well as the plush low-density suburb of Borrowdale. The other areas near the settlement were vast commercial farms spreading further into Mazowe District. In her study, Manyati (2005:15) estimated poverty levels in the settlement to be around 90%, virtually rendering almost everyone in Hatcliffe extension as poor. While Government's intentions were for Hatcliffe Extension to be only temporary while the inhabitants were being vetted for resettlement elsewhere, its subsequent incapacity to provide proper housing led to the settlement becoming more or less permanent (Stevenson, 2005). Wooden cabins were then put up by Local Government and rented out, and other forms of accommodation included plastic, grass and metal sheet shacks put up by the local people. A satellite clinic was then set up by the Ministry of Health and Child Welfare and the District Development Fund (DDF) drilled boreholes for water. Non-governmental organizations also came in with provision of water and sanitation facilities as well as extra medical treatment for the community. However as posited by the Children's Consortium (2002:3-5), increasing population pressure due to migration into the settlement overwhelmed its carrying capacity and the few social services and support systems available. Consequently people began constructing their own unstandardized shallow pit latrines to ease pressure on the communal facilities and trends of sanitation related diseases began showing in the settlement. Manyati (2005:15-17) noted that the main health concerns in the Hatcliffe Extension settlement were dysentery, diarrhoea, bilharzia, helminth diseases, respiratory infections and increasingly HIV and AIDS related illnesses. Stevenson (2005) also

quoted HIV prevalence of between 40-45% as well as noting that an average of 20% of the households in the informal settlement were child-headed and 45% were female headed.

In the month of May 2005, the Hatcliffe Extension informal settlement was among the areas affected by the Government of Zimbabwe (GoZ) clean-up exercise code-named Operation Restore Order/*Murambatsvina*, which was meant to rid urban areas of informal settlements as well as informal trading markets and stalls (alleged to having been fuelling crime and illegal foreign currency dealing). Settlers from this community were cleared from their areas of habitation and were temporarily taken to Caledonia Farm transition camp (about 25km East of the capital Harare), waiting supposedly to be ferried to their rural homes. After a few weeks though, the settlers were returned to Hatcliffe Extension, though this time they were put on the pieces of land allocated to them as residential stands. This however saw the re-emerging of the slum, this time even worse than before because there was even less access to the few amenities like safe water and Blair toilets, that had been developed before the clean-up. Due to high costs of putting up wooden cabins, most of the settlement was now characterized by shelters made of plastic and metal sheets.

3.2 Research Design

The study was premised on a descriptive case study methodology which was seen as ideal for providing a holistic, in-depth investigation (as asserted by Feagin *et al*, 1991) into the challenges of the HIV and AIDS pandemic in the informal settlement. The same authors noted that such an approach had strength of being multi-perspectival in its analysis i.e. it would allow information to be collected from multiple groups of respondents in a reasonably small area of confinement. While the author Tellis (1997) noted that literature frequently criticized case study research in that its results were not automatically generalizable and widely applicable to other contexts, the publication by Yin (1984) by and large laid to rest such criticism by

clearly explaining the difference between statistical generalization and analytical generalization. In his explanation, Yin showed how it would obviously not be possible to generalize statistics and figures from a particular case since these would naturally be site-specific, but general analysis could be inferred to other cases with more or less similar dynamics.

The design put particular consideration to enhance research reliability (consistency of measurement) as well as validity (strength of conclusions, inferences or propositions with respect to the subject under study). The research instruments were therefore developed after an extensive review of literature to ensure that they captured the relevant information and so maintained uniformity throughout the study. In order to ensure validity, the study made use of triangulation techniques in which multiple sources of data collection were used, and these included document review, key informant interviews, focus group discussions, in-depth interviews, a questionnaire-guided survey, informal discussions as well as observations. The data collection tools were pre-tested so as to cross-check them for reliability and validity of research findings.

3.3 Limitations of the Study

The Government of Zimbabwe's Operation Restore Order/*Murambatsvina* became a major obstacle in this particular study as it interfered with data collection, particularly the adolescents and adults survey as well as observations of events in the community. Some of the key informants were also displaced and had then to be located after the Hatcliffe Extension settlers had been returned from the holding camp. When the people were sent back to Hatcliffe Extension, there emerged a certain level of political sensitivity in the community as there were army officers among other Government operatives who were either manning the home building Operation Rebuilding/*Garikai -Hlalani Kuhle* project or were merely observing if there

were no people seeking to assess the impacts of Murambatsvina for media consumption purposes. This scenario obviously hampered with unrestricted data collection at some stages in the study. Another challenge was also faced on the issue of document review as the organizations running various programmes in the community were reluctant to share what they termed ‘confidential’ project documents. Some of the detailed statistical information therefore, especially from medical records and project reports was thus limited.

3.4 Data Collection Methods

3.4.1 Document Review

The available reports on various development work that had previously been done in the informal settlement by government departments, Non-Governmental Organizations (NGOs) and Faith-Based Organizations (FBOs) were reviewed to get background understanding of HIV and AIDS-related programme efforts in the area. Also reviewed were registers compiled by NGOs as well as FBOs supporting OVCs and People Living with HIV and AIDS (PLWHA) and all this literature assisted in establishing the dynamics of HIV and AIDS in the settlement. Assessing previous efforts highlighting challenges on tackling the HIV and AIDS pandemic in Hatcliffe Extension also helped in refining research instruments so that they put more emphasis where there were information gaps.

3.4.2 Key informant interviews

Through the use of a semi-structured questionnaire, key informant interviews were carried out with local leadership in the settlement, MoHCW officials, Local Government officials, members of the DAAC and WAAC, care givers, traditional healers and church leaders to have an assessment of how HIV and AIDS had impacted on the particular community. The interviews also sought to establish what these key informants perceived to be the main drivers of the pandemic as well as capture their recommendations on

what could be done to prevent the further spread of the pandemic in the area. A separate guide was used in the key informant discussions with implementing agencies; that is the various NGOs, FBOs and NAC working in any of the areas pertaining to HIV and AIDS prevention, mitigation, care and support as well as treatment. The discussions sought to find out what challenges the organizations saw in implementing HIV and AIDS work in the area as well as to hear their perspective on good practices and recommendations on the most effective ways of reducing risk and vulnerability of HIV infection and spread in these areas.

3.4.3 In-depth Interviews

Three categories of in-depth interviews were carried out in this study. The first one was in the form of a Knowledge, Attitudes, Practices and Behaviour (KAPB) survey in which adolescents and adults (18-60 years range) were interviewed using a semi-structured questionnaire on their knowledge, attitudes, practice and behaviour with regards to sexuality issues. This was with the premise that this group comprised the majority of sexually active individuals in the community. The questionnaire in this survey also had the Condom Use Self-Efficacy (CUSE) Scale (see Brafford and Beck, 1991:219-225) in it to ascertain levels of self confidence in adopting safe sexual conduct in various circumstances among the most reproductive and economically productive ages. While it was acknowledged that some adolescents between 15-17 years could have already been sexually active and so should have been part of the KAPB survey, the pre-test had shown this category to be uneasy in responding to questions on the Condom-Use Self Efficacy Scale. This age-group was thus left out of the survey for ethical reasons and was included the focus group discussions (see section below). The second category of in-depth interviews was that with People Living with HIV and AIDS (PLWHA). An interview guide was used in this determination and case studies on their challenges and experiences were also noted in the process. The last category of in-depth

interviews involved questionnaire guided interviews with OVCs, which sought to ascertain both the physical and psychological challenges associated with orphanhood in the settlement. The questionnaire also had a component of the Child Depression assessment checklist, adapted from Sengendo *et al* (1997:124) for the assessment of depression among OVCs in the area. In the checklist, 25 questions were asked and the individual scores added. Total scores of 18 and below signified no depression in children, but 19 and above signified depression.

3.4.4 Focus Group Discussions (FGDs)

With the aid of FGD guides, focus group discussions, each consisting of between 6-10 people were held with adolescents as well as adults in the community to assess their knowledge, attitudes, practices and behaviours as they related to sexuality and HIV and AIDS. For each of the categories, an FGD was done for the males and another for the females to ensure that the respondents would be free enough to express themselves about sexuality issues without feeling restricted by the other sex. Another focus group was also carried out for orphans as well as children heading households to establish the sort of socio-economic as well as psycho-social problems their predicaments were giving them. There was also yet another FGD with grandmothers in view of their increasing role in caring for their grandchildren as their sons and daughters were succumbing to the disease. The FGD sought to clearly understand what challenges the increased burden of care was giving the elderly people considering that they also needed care because of their age.

3.4.5 Observations

The final method of data collection was the checklist-guided observations that sought to bring about a deeper appreciation of the informal settlement's social, political economic and environmental dynamics. The various aspects of the informal settlement that were being observed therefore were the housing conditions, water and sanitation situation, social and political gatherings as well as the various economic and recreational activities in the area.

3.5 Sampling Techniques

Random sampling techniques were employed to select respondents for the two quantitative determinations in the study i.e. the KAPB survey as well as the OVCs situational assessment. For the survey, a sample size of 373 was reached at using the sample size determination formula (see Annex 1). With the area having an estimated 450 households and requiring 373 respondents from these households, calculator-generated random numbers were used to come up with the desired households to be sampled in the study. For every household sample, a male and a female respondent within the 18-60 years age range were to be randomly sampled if respondents of both sexes were present. In cases where respondents were all of the same sex, a respondent would still be sampled randomly. Households that did not have a respondent in the required age range were skipped to the next chosen household. Now as a result of Operation Restore Order/*Murambatsvina* which resulted in the displacement of people from the Hatcliffe Extension informal settlement, as pointed out in the limitations of the study above, sampling for this particular aspect of the study was disrupted.

As a result, the sample size, N ended up becoming 102 (sampled according to the random sampling design above) instead of the ideal 373. The sample had 60 males and 42 females. In order to assess the plight of orphans and other vulnerable children in the settlement, the Ward AIDS Action Committee (WAAC) register of the orphans in the informal settlement was used as the sampling frame. Random sampling techniques were then used to select orphans between 6 and 18 years of age for the in-depth interviews as well as the focus group discussion. The selection of PLWHA for the in-depth interviews with this particular group was done purposively as some of the PLWHA were not willing to speak to 'strangers' concerning their plight. Those who were willing were the ones eventually considered for the interviews.

3.6 Data Analysis Techniques

Qualitative data collected from the key informant and in-depth interviews as well as focus groups were transcribed, translated to English (where necessary), and entered verbatim into a computer as data files for text analysis. The qualitative data transcripts were then further read and analyzed, searching for key words, phrases as well as ideas that would help to answer the research questions. Quantitative data was analyzed using the Statistical Package for Social Sciences (SPSS) software. Both forms of data therefore formed the basis on which research questions sought to be answered and objectives attained.

3.7 Ethical Considerations

Owing to the fact that HIV and AIDS is a sensitive topic, and that people are generally not too keen to talk about their personal lives, especially sexuality, careful consideration was paid to ethical issues in the study. Those respondents that had been selected as part of the sample who were not comfortable to discuss issues pertaining to sexuality or HIV and AIDS issues were excused from the study and those who participated agreed to a statement of consent to confirm their understanding of the study as well as their willingness to participate. OVCs were not forced to discuss their plight and authority had to be obtained from their responsible guardians before including them as part of the sample. Some of the children were too distressed to discuss what they were going through, and still these were not manipulated or forced into doing so. Names of all the case studies were changed to protect the people's identities. Since the study was also generally taking place in an area with high poverty levels, people would then tend to expect to receive material or financial incentive after participating in the study. It was therefore clarified from the beginning that the study would pay the community back in the form of giving guidance to policy as well as in advocacy for the concerted focus by development partners including government, civil society and private sector towards alleviating the plight of people in informal settlements with regards to the HIV and AIDS pandemic.

CHAPTER 4

4.0 FINDINGS OF THE STUDY

4.0.1 Introduction

With the preceding three chapters having given the background and introduction, the rationale, objectives, the theoretical as well as the methodological frameworks to the study, Chapter 4 proceeds with giving the actual findings from the study. It looks at the outputs and results that came out from the various forms of data collection clearly articulated in the previous chapter. As an entry point, the chapter begins by going through the profile of the respondents and then goes further to elaborate on the factors increasing risk and vulnerability to HIV infection and spread in Hatcliffe Extension, as per the findings. The next section of the findings in this particular chapter then looks at the HIV and AIDS crisis in the area under study, looking at the plight of People Living With HIV and AIDS (PLWHA), Orphans and other Vulnerable Children (OVC) as well as giving a critical analysis of the response framework which was being implemented by various AIDS service organizations working in that particular community.

4.1 Profile of the Respondents

The study had eight (8) key informants from the various organizations and government departments that were working in Hatcliffe Extension. There was a key informant from the Ministry of Local Government, one from the Ministry of Health and six (6) were from local NGOs that had various developmental programmes in the area. Three (3) local leaders were also part of the key informants group, as well as two (2) pastors from local churches in Hatcliffe Extension. Two traditional healers, one an African Traditional Religion healer and the other an Islamic faith healer also formed part of the key informants group.

Six (6) in-depth interviews were also done with PLWHA in the community and case studies were thereby taken note of. The KAPB survey among the most sexually reproductive age group (18-60 years) had a total sample size (N) of 102, with 60 males and 42 females. The study also had as in-depth interview respondents 37 orphans who had been allowed by guardians to participate in the OVC situational assessment. For comparison purposes, a further 13 children who were not orphans were also randomly selected to bring the total sample size (N) to 50 for that particular determination. Of the total sample size used in the OVC situational analysis, 21 (13 male, 8 female) were double orphans, that is they had both parents late. 8 (3 male, 5 female) had a late father and 8 (4 male, 4 female) had a late mother. The control part of the sample consisted of 4 males and 9 females. Finally, seven (7) Focus Group Discussions were held with the youth (one group male, the other female), adults (one group male, the other female), grandmothers and the last two groups had OVCs, among them some who were heading households, and these were disaggregated according to sex.

4.2 Factors Increasing Risk and Vulnerability to HIV infection and spread

4.2.1 Poverty and Unemployment

In key informant interviews, in-depth discussions, focus groups and even from observations, it clearly emerged that poverty was the major factor driving the spread of the HIV and AIDS pandemic within the informal community. In the KAPB survey, 62 (60.8%) of the respondents were indeed of the opinion that poverty was mostly exacerbating the spread of the pandemic. While other factors like child sexual abuse, 'loose morals', inadequate housing as well as social re-engineering were also highlighted, the issue of poverty clearly stood out, as shown in the table below :

Factors Increasing risk to HIV and AIDS	No# of Respondents	%
Poverty	62	60.8
Loose Morals	15	14.7
Child Sexual Abuse	8	7.8
Inadequate Housing	11	10.8
Social Re-Engineering	6	5.9
TOTALS	102	100

Table 1: Respondents’ Perceptions of Factors increasing HIV and AIDS risk

Due to unemployment and redundancy, young men were said to be engaging in crime while their female counterparts engaged in commercial sex work as well as getting involved in numerous inter-generational risky sexual relations so that they could get money for food and non-food basics. Early marriages were also typical in the area as young girls failing to get money to proceed to secondary school chose to rather get married and so have a man to look after them. The highly desperate situation of young women, particularly those heading households to make a living, even to the extent of having multiple partnerships (with each partner having his own sexual demands), was subsequently disempowering them from negotiating for safer sex (using condoms) during transactional sex. Results from the Condom Use Self-Efficacy scale used in the KAPB survey to assess confidence in protective sexual behaviour indeed gave evidence to that effect, as the females were generally shown to have diminished self-confidence in initiating condom use in sexual relationships. The table below illustrates responses to the question of confidence in discussing condom use with a new partner before any form of sexual contact.

	I would feel comfortable discussing condom use with a potential partner before we ever had any sexual contact				
	Strongly Disagree	Disagree	Agree	Strongly Agree	Total
Male	4	8	33	15	60
Female	0	18	12	12	42
Total	4	26	45	27	102

Table 2: Comfort in discussing condom use with a new sexual partner

Evidence from the table generally shows that women were less comfortable to discuss condom use with new sexual partners, as indicated by 18 (42.9%) of the women disagreeing to the question of being comfortable in discussing condom use with a new partner before any sexual contact. This was in contrast to a total of 12 males (representing 20% of the males in the sample) who both disagreed and strongly disagreed to the same question of discussing condom use with a new partner before any sexual conduct. Even for those who affirmed that they would be confident in discussing using condoms with new partners, the total for males who both agreed and strongly agreed to that effect was 48 (80% of the males) compared to 24 (57.1%) for the females. In another determination from the Condom Use Self-Efficacy scale, it was also established that 14 (23.3%) of the males said they would suggest using condoms even if they were unsure of their partners' feelings towards condoms. This was in comparison to only 6 (14.3%) of the females who pointed out that they would do the same. It was therefore apparent that initiation and general discussion and negotiation for condom use was an uphill task for women. Such reality of diminished confidence in initiating condom use was also substantiated in the focus groups in which women confirmed that they feared losing their partners who could potentially take care of their material and other livelihood needs if they insisted on condom use against their partners' wishes. Some men preferred uncondomised sex, for which they would obviously pay more to their sexual partners; therefore it was difficult on the part of women to outrightly insist on the use of condoms (since uncondomised sex meant more money), although they would be aware of the risks involved in unprotected sex. Another related challenge with regards to condom initiation that the women highlighted in the FGD was that it was generally difficult to initiate condom use with a new sexual partner without making it seem like the latter either had an STI or HIV. They also pointed out that societal expectations for women to be submissive in sexual issues only made condom negotiation more complex.

As a result, it was reported that there were many cases of unwanted pregnancies, abortions and baby dumping among young women in Hatcliffe Extension. While they were aware of the dangers of multiple sexual relationships; the young women were saying there was nothing they could do since they were looking for means of survival. Since the area had so many poor people, any man who showed little signs of relatively better income e.g. possessing a radio at their homestead would be a potential partner. The case study below gives a typical scenario showing the desperation of young unemployed women in the community, resorting to commercial sex work as a means of survival.

Chiwoniso (*Not her real name*)

I have a child whose father I will probably never know. What happened was that I met this man at some bar on a nearby farm. The bar was inadequately lit, and so when the man proposed to give me money for having unprotected sex with him, I just consented without necessarily seeing his face or who he was. We went into a shelter just outside the bar that also did not have any lighting and we spent the night together. Just before dawn, he gave me my money and said he was leaving, to which I had no problem since he had given me my dues. I later discovered I was pregnant and that is how I eventually gave birth to my child. I wonder what I will tell my son when he demands to know where his father is.

Young people, both male and female also lamented the lack of recreational facilities in the community; therefore they tended to find respite in alcohol at the local shebeens, drugs (especially for the males) and eventually multiple sexual relations as ways of entertaining themselves. It goes without saying that these factors increase the risk of spread of HIV infection.

4.2.2 Child Sexual Abuse

While there were no documented records, it emerged from focus group discussions and key informant interviews that the informal settlement had rampant cases of child sexual abuse happening, and for some reasons a number of them were going unreported or took time to be reported. A striking case was of a father who had literally made one of his daughters his sexual partner after the death of the wife. The story only came to surface when father and daughter had a fierce argument one day, and when elderly women in the community tried to make her desist from disrespecting her father that way, that is when she pointed out that people did not need to worry since she was not fighting with her father, but her husband (inferring that she was sexually involved with her father). The case took long to be reported as the perpetrator was a soldier and people in the community were afraid to go and report him to the police for fear of retribution. Another case that was noted during the study was of a girl who was expecting her father's child. Numerous other cases involving minors, mainly orphans staying with extended family members were also established. During the days of fieldwork, another case of a 9-year old orphan who had been allegedly raped numerous times by a 20 year-old cousin into whose family she had been adopted was reported. The father of this perpetrator was a traditional healer who is alleged to have raped his own mother at some point! The case was handed over to the police but strangely, after a few days the charges were withdrawn as the family pledged to get to the bottom of the story out of court. Probably because of not knowing where to report, a child who must have heard from her friend that the latter had been sexually molested wrote a message on a water tank with a piece of charcoal which read "*Kuna amai, mwana wenyu arikubhinyiwa*" (Literally translated, means: *dear mother, your child is being sexually abused*).

It was concluded that this particular child might have meant for the mother of the abused girl, who most likely used this water collection point frequently to see the message and act accordingly. With many parents and guardians leaving their children unattended to when they went off to look for means of survival either in nearby farms or in the city, children were left exposed to abuse. Child abuse was therefore noted as one of the major factors exacerbating the spread of HIV infection among children, particularly the girl-child.

4.2.3 Sex Networking

One of the major challenges towards containing the pandemic in the Hatcliffe Extension informal settlement was the rampant sex networking inherent in the area. Vulnerability enhanced by poverty and general lack resulted in the formation of a complex web of sexual interaction that inevitably increased risk of spread of the HIV and AIDS pandemic not only in the community, but in its surroundings as well. What further complicated the sex networking was the fact that the informal settlement had pockets of high income in the form of men and women from the nearby Borrowdale and Hatcliffe areas as well as government and other workers (directly working in the community) with significantly higher incomes than the majority of people in the informal settlements. It therefore meant that there was a consistent demand for sex from the relatively wealthier men and women surrounding the informal settlement, and the poor men and women of Hatcliffe Extension being the consistent suppliers. The diagram below illustrates the sex networking in Hatcliffe Extension.

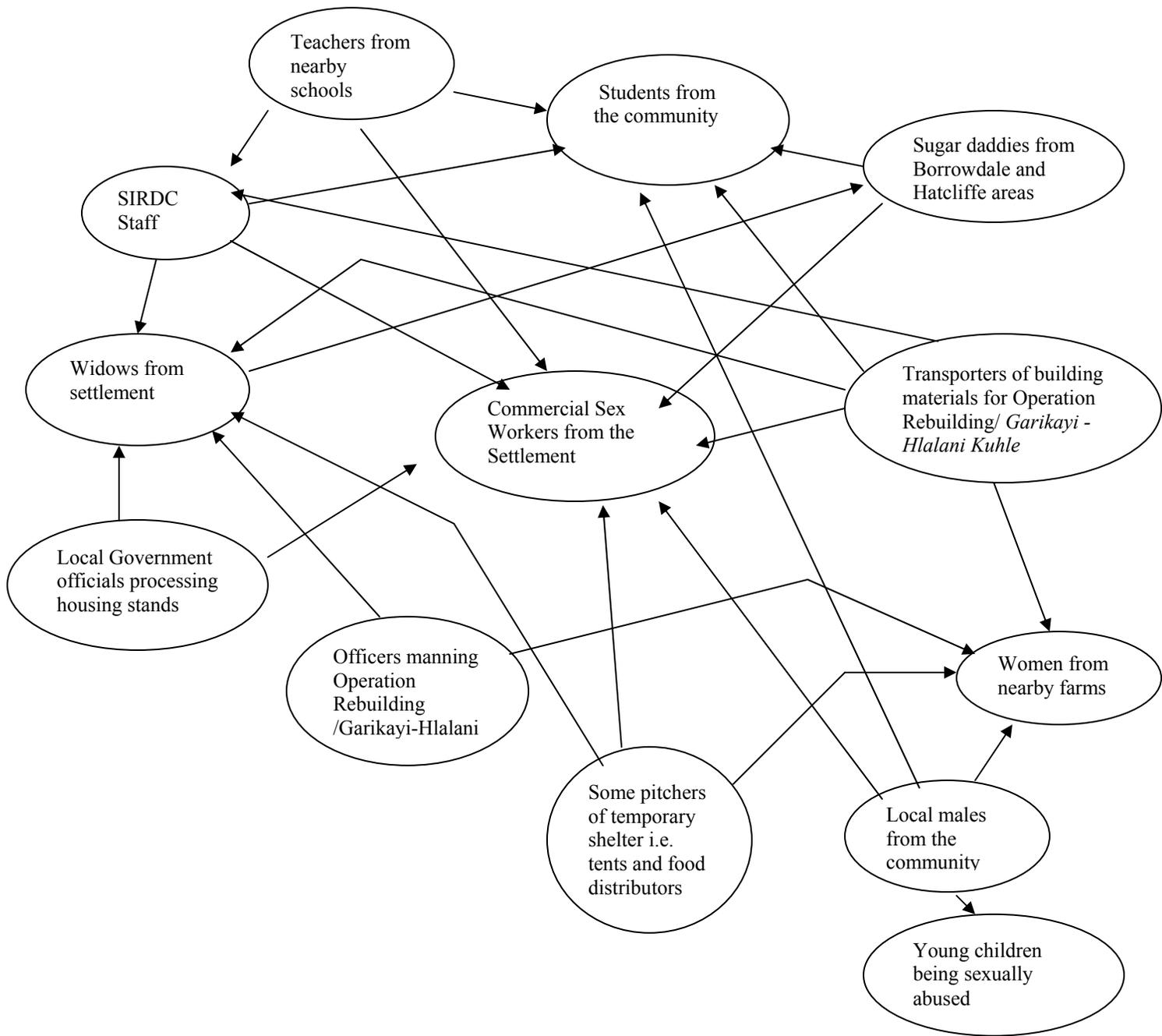


Figure 6: Sex Networking In Hatcliffe Extension

4.2.4 Social Re-engineering

One of the significant characteristics of the settlement were the levels of cultural diversity and different ethnic groupings that had been brought together as a community through the various displacements, movements and relocations that had resulted in the formation of this particular settlement. There were three main lines of religious grouping in the settlement, and these were Christianity, Islam and African Traditional Religion. Consequently, a lot of social re-engineering had occurred because of the inevitable socio-cultural mixing and interaction amongst inhabitants of the community. Practices like *chinamwari*³ and *zvigure / zvinyahwo*⁴ had become commonplace in the settlement, and these mixed with the local Shona and Ndebele cultures also predominant.

Other practices that had become deeply ingrained in the community as well included wife inheritance, polygyny and *chiramu*⁵. While some elders in the community felt it was a good thing for the community to be an interface for so many cultures as it presented an opportunity for intercultural learning, a disadvantage was seen in that there were now no common cultural norms and value systems upon which to base behaviour and conduct, especially relating to sexuality, as each culture had brought its own set of standards.

³ An initiation tradition of Malawian and Zambian origin in which young adults are taught on issues of courtship and how to treat their partners when married, among other life-skills

⁴ Dance festivals of Malawian origin in which dancers dress in fetish and animal-resembling regalia and perform in groups. These groups are also said to be religiously based

⁵ Cultural practice in which men take their wives younger sisters as their other wives and would end up touching their breasts and private parts in the name of ‘playing with their wives’

Wife inheritance and polygyny were perceived to be fuelling the spread of infection as some of the spouses would have lost their partners through HIV and AIDS and others would have been involved with infected partners while *chiramu* was seen to be increasing chances of child sexual abuse by adults. The elderly also lamented the loss of traditional practices like the guidance and counseling of young people by aunts and uncles as the former were approaching adulthood. Such a gap was reportedly being seriously felt in this present era in which the youth were perceived to be recklessly indulging in risky sexual behaviour resulting in the spread of HIV and imminently the increasing in the incidence of AIDS in the community.

4.2.5 Inadequacy of Housing

Inadequacy of housing was also identified in the study as another feature in the increasing of risky sexual behaviour and abuse of children, factors fuelling spread of HIV in the community. Parents were raising concern that they often had to partition their houses using curtains, and children would obviously hear whatever would be taking place in the parents' bedroom when they were being intimate. It meant that their children would also go on to experiment with sex, and often this lead to unwanted pregnancies and ultimately spread of infection. Overcrowding in the already partitioned rooms, particularly in cases where fathers or relatives slept with minors on the same bed increased chances of sexual abuse of young girls. The overcrowded conditions were also attributed in increasing spread of air-borne illnesses like Tuberculosis among others.

4.2.6 Domestic Disputes and Violence

It emerged from discussions with local leadership from the area that domestic disputes and violence were also contributing to sex networking and the spread of HIV in the area. Typical examples given were of men who would leave their spouses after disputes in the home and move in with other women within the community or in nearby farming areas. After a while they would then return to their families and with them having been with other partners and chances that their spouses had been as well, probability of spread of infection would therefore increase. Women would also run away from their partners after spates of violence in the home, only to return after a period that the men would likely have been with other partners. There was a case noted during the study of a woman who had a dispute with her husband after he had tested HIV positive. She then moved out of her matrimonial home and the husband got involved with an HIV positive carer, who actually moved in with him. After a while the woman who had left her husband decided to come back only to establish that her husband was now involved with someone else.

4.3 The HIV and AIDS Crisis in the Community

There was indeed wide acknowledgement in the community right from the local leadership to the community members that HIV and AIDS was bringing about the worst health concerns compared to other diseases. In discussion with a key informant from an NGO running a health facility in the area, it emerged that AIDS-related illnesses including tuberculosis, meningitis and herpes as well as sexually transmitted illnesses (gonorrhoea and syphilis) accounted for 70% of the health concerns in the informal settlement. All the 102 respondents in the KAPB survey understood HIV and AIDS as an incurable disease that was transmitted mainly through unprotected sexual intercourse, including sexual abuse. The other methods of spread of HIV infection were identified as Parent-to Child Transmission (PTCT) as well as the sharing of sharp instruments like needles and razorblades. 80 (78.4%) of the survey respondents indeed felt that the

pandemic was a serious problem manifesting itself through high mortality and morbidity rates among the most sexually productive and economically active individuals. The pandemic was also said to be evident through the rising number of orphans and child-headed households in the community. On the question of who was perceived to be most at risk of contracting HIV and AIDS, 31 (30.4%) of the KAPB survey respondents said the youth in general as they were mentioned to have no recreational facilities, so they tended to experiment with sex as a form of entertainment, 57 (55.9%) said young women because they were being forced to use their bodies as means of survival especially in the currently harsh economic climate ;14 (13.7%) of the respondents said girl-children because of their susceptibility to rape and sexual abuse.

Even religious groupings (Christian, Islam and African Traditional Religion) were acceding to the fact that their own congregations were also decimating due to HIV and AIDS. One of the leaders of a Christian sect in the community pointed out that HIV and AIDS had become an undercover disease in the church as people were not disclosing but high rates of death and illness were apparent. Since the position of the church was on abstinence before marriage and faithfulness in marriage, disclosure of one's positive HIV status was therefore bound to be difficult as coming out meant those positive people would be deemed to have committed adultery or breached the abstinence/faithfulness standard, hence be stigmatized or discriminated against. People were therefore said to be just coming for prayers and counseling without necessarily disclosing their status, despite apparent signs and symptoms indicating HIV and AIDS-related illnesses. The same respondent also noted how difficult it was to teach on condom use in the church as it was seen as encouraging premarital sex and unfaithfulness amongst members of the congregation. However, women were being encouraged to note symptoms in their husbands and initiate condom use.

Perspectives of the religious leaders spoken with during the study were to the effect that women (especially grandmothers) were bearing the worst brunt of the pandemic because of their bigger burden of care, followed by children who would be left with no one to take care of them after the loss of parents due to the pandemic. AIDS was also accepted across all religions as being incurable, though traditional healers from the ATR and Islam claimed to possess herbal medicines that could reduce the viral load as well as treat opportunistic infections. The main causes of high levels of infection and spread of the pandemic in the community were noted again to be poverty which was exposing people, particularly women to high-risk sexual behaviour as a livelihood strategy. Leaders in the religious sects expressed concern that sexual conduct was not being accorded its due sanctity and there were now lots of cases of casual sexual conduct not sanctioned by the institution of marriage. Absence of exemplary elderly in the community to advise and guide the youth on the right moral standards of behaviour was also attributed to the rise of HIV and AIDS as the elderly were seen as not to be leading by example themselves when it came to sexuality issues. There was common consensus that AIDS had no cure as yet, although certain traditional medicines as well as anti-retroviral drugs were affirmed to reduce the viral load and thereby prolong life in infected individuals.

4.3.1 People Living With HIV and AIDS

Records from the WAAC register indicated that Hatcliffe Extension had 116 registered people living with HIV and AIDS, of which 84 (72.4%) were female and 32 (27.6%) were male. These people had undergone Voluntary Counseling and Testing (VCT) and were receiving food aid and medication from the local DAAC as well as other NGOs and Faith-Based Organizations (FBOs) working within the settlement. Key informants from the WAAC however indicated that the numbers could be more as many other people had not openly come out that they were living with the disease.

A closer look at the data on People Living With HIV and AIDS (PLWHA) in Hatcliffe Extension indicated that more women were being infected from the much younger age range (22-30 years) compared to their male counterparts. In that particular age category, as the graph below illustrates, 7 women compared to 4 men were living with HIV and AIDS. This also gave evidence to the engagement of young women in intergenerational sexual relationships with older men as a livelihood strategy. This characteristic was however exactly the opposite after 55 years as more men (10) were now infected compared to their female counterparts (2). This gave an indication as well of older men taking part in intergenerational sexual relationships with younger women. The data also showed that four age ranges had significantly high peaks of infected women, and these were the 36-40 years range (20), followed by the 46-50 years range (15), then the 41-45 years age range (13), and finally the 51-55 years range (10). Apparently this was in sharp contrast with the number of infected men in these categories, the numbers being 2, 4, 4 and 3 respectively. Again such evidence only confirmed the general greater vulnerability of women with regards to HIV infection as already established from the other results. The below graph illustrates the above information:

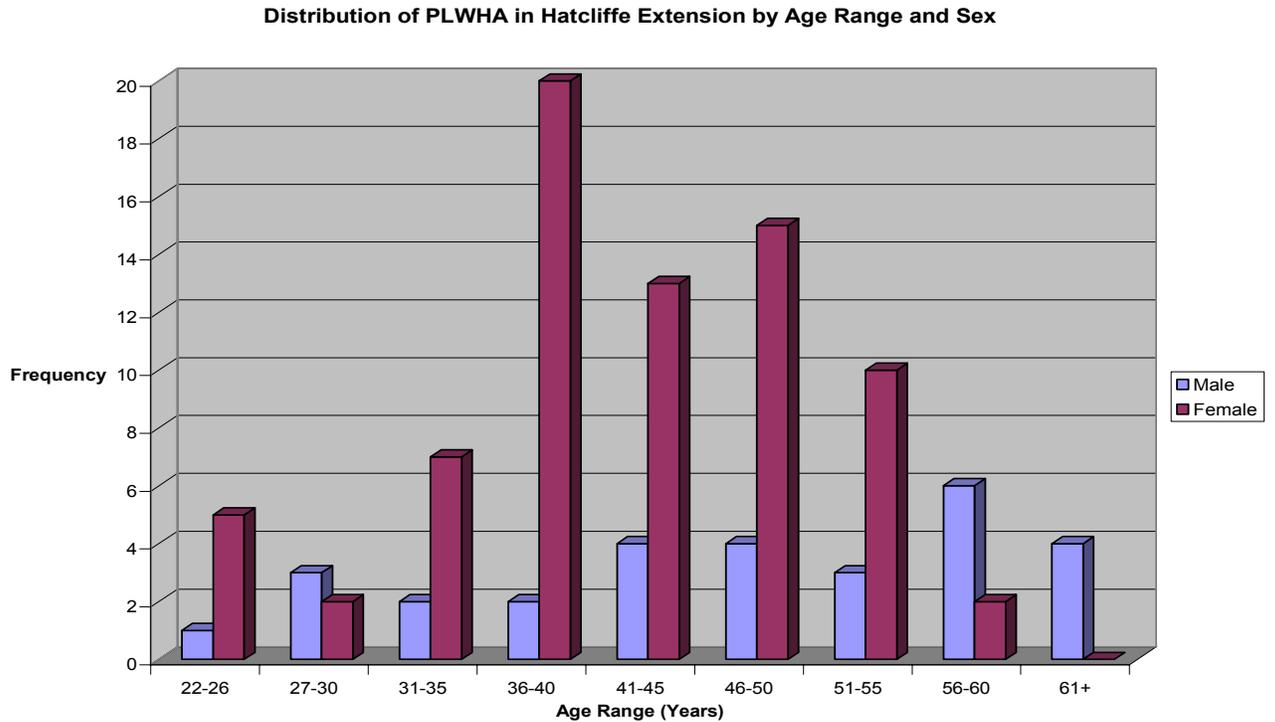


Figure 7: Distribution of PLWHA in Hatcliffe Extension by Age Range and Sex

4.3.2 Case Studies - Challenges of Living with HIV and AIDS (Real names not used)

Chipo Chikozho 57, female

My husband passed away and he was promiscuous. After I had suffered from prolonged tonsillitis I went to get tested and was found to be HIV positive. I did not receive any counseling to help me cope with my newly discovered condition. I stay with my grandchild and receive little support from my married daughter. There are irregularities in programmes that give medication (ARVs); I have only managed to access pain-killers. Food supplies for HIV and AIDS patients are insufficient. We are also in need of soap. People living with HIV and AIDS should be given income-generating projects so that they would not just depend on food aid from donors. Because of thrush infections, I need to brush my teeth everyday, but unhygienic water supplies might increase infection in my mouth. The poor states of the dusty roads are increasing the risk of air-borne infections. Many times I need people to talk to, but they always avoid me. I have lost all hope in this life; I am just waiting for my time of death.

Lindiwe Guzha's Testimony

I have been a home-based carer for 12 years, and am HIV positive. I strongly suspect that I got infected by HIV during care of AIDS patients because I have never known any other man besides my husband, who is HIV negative. I initially did not want to go and get tested with other fellow carers. However after I was tested I then went on ARVs. Many people in the community think that I have justifiably reaped the rewards of being promiscuous, yet I was never. My husband also does not understand my plight and probably thinks I could have gotten infected from promiscuity as well.

4.3.3 Children Living With HIV and AIDS

While there was acknowledgement that there were child cases of HIV and AIDS, there was no database for children as there was for adults living with HIV and AIDS. A member of the WAAC pointed out that parents were for some reason not too keen on taking their children for VCT. A possible reason given was that perhaps the parents were afraid that if their children tested positive, chances would be that they would be HIV positive too, so they probably felt it was better not to know at all. The below cases illustrate the challenge of HIV and AIDS in children.

Case Study 1 - Blessed Manyore - 10 years old

Blessed lost both her parents and so she moved in with her grandparents. After being persistently ill for a while she got tested during a routine visit to the hospital for treatment. She tested positive for HIV and has been receiving food aid and medication for opportunistic infections from organizations working in the area. She however lamented that food supplies and treatment were inadequate. She also mentioned that other children did not want to play with her because of her condition, so she played all by herself.

Case Study 2 – Letwin Mwanza-16 years old, female

The young girl had stunted growth, apparently looking very wizened and with the built of a 10-year old. Both her parents were late and she was staying with her grandparents. She had always been a sickling since birth and upon one of her regular visits to the hospital was she diagnosed to be HIV positive. She never received counseling to help her cope with her status and she lives in continuous fear of what will happen to her from the time of her diagnosis. Her maternal relatives who had been giving her support from the time of the death of her parents stopped doing so upon establishing her HIV status, and this was a time she really needed help since she was having Tuberculosis. Although getting few supplies in terms of food aid and medication for opportunistic infections from one organization working in the area, she lamented that these were not enough to cater for her needs. She also pointed out how she had observed influential people in the community manipulating their authority to get food assistance meant for people living with HIV and AIDS.

4.4 The Plight of Orphans and other Vulnerable Children

The study established that there was a serious OVC crisis in the area. Records approximated that at least 300 children were orphaned in the area and some of them were heading households. Their main challenges included not attending school and absenteeism because of having no one to pay fees for them or buy uniforms and other materials required at school. There were cases where school-going children were still in pre-school (crèche) because they had no one to pay for their school fees. In some cases children would not go to school because they would not have eaten, so they would be too weak to go and learn. Some of the children in the study were visibly malnourished.

While the situation was generally bad for the orphans and other vulnerable children, it was even worse specifically for those children who were double orphans. As pointed out by one key informant in the study, scenarios occurred where if a man or woman lost a spouse, they would marry again and upon their

passing away, the surviving step-parent would remarry, therefore the children would end up having double step-parents. It is such cases in which rampant child abuse was reported including sexual abuse and child labour. The step-parents were said to force children (the girl-children) to have sexual relations with older men as well as to go and work in the nearby farms to supplement the family income, otherwise they would not be given any food. Even children who would have lost their fathers but still stayed with their biological mothers were also reportedly going to work in the farms to help their mothers in raising household income, of course at the expense of going to school.

As was pointed out by a key informant from an organization that had a programme on school fees support in Hatcliffe Extension, the working children often did not do well in school because of the many days they would be absent as they would be working on the farms. The school report below gives a typical scenario of an orphan who had lost both parents and was being made to go and work in the farms to supplement the household income by step parents⁶:

⁶ The name of the pupil was changed to protect their identity

HATCLIFFE 2 PRIMARY SCHOOL

ZAMBUKO SCHOOL

NAME OF CHILD Chikoshana Phiri Alexander

GRADE 4 A TERM TWA YEAR 2004

POSITION IN CLASS 15 OUT OF 39

SUBJECT	POSSIBLE MARK	ACTUAL MARK	COMMENTS
MATHEMATICS	80	34	Work hard
ENGLISH READING			
ENGLISH WRITTEN	80	33	Work hard
SHONA READING			
SHONA WRITTEN	80	49	Wagona
CONTENT	80	14	Work hard
TOTAL	320	130	Can do better

CLASS TEACHERS COMMENTS *His performance is not pleasing although he sometimes tries hard. He should always come to school and avoid absenteeism.*

TEACHERS SIGNATURE *M. Mure*

TIC'S SIGNATURE *A. M.*

HEADS SIGNATURE

NEXT TERM COMMENCES 07/09/2004

ZAMBUKO PRIMARY SCHOOL
END HATCLIFFE 2 PRIMARY SCHOOL
P.O. BOX 571030
BORROWDALE, HARARE

SCHOOL STAMP

THIS REPORT ISSUED WITHOUT ANY ALTERATION

Figure 8: Case of Working Child Absenting from School

4.4.1 Psycho-social Aspects of Orphanhood

Apart from the physical and material needs of OVCs in the settlement, there was also evidence of unmet psycho-social needs among the children. 26 (70.3%) of the orphaned children who were assessed for depression in the study said they had at some point been in the caring for their ill and bed-ridden parents, ranging from feeding them, taking over household chores and looking after siblings among other chores. The increased burden of care apparently weighed down on the children, who still had to balance the burden of care with going to school. As a result, as established from the FGDs, children ended up having psychological stress which was worsened upon the death of their parents and having no one to help them cope with their new situations. As noted in interviews with the children, their feelings ranged from sadness (16 respondents), anger (9 respondents), and loneliness (7 respondents) to confusion (5 respondents) after the death of their parents, and this was a clear indication of the traumatic and disturbing experiences the children underwent. After the death of a parent or both of them, the shock of having to take over breadwinners' roles, coming to terms with the loss of a loved one or in cases taking care of a surviving parent (in most cases ill too) also added more stress and mental pressure on the children. Cases were also noted in which children (after losing their parents and having moved in with relatives) were being subjected to abuse in their adopted families, for example being overworked at the expense of going to school, being underfed, physically and even sexually abused. This without doubt also further aggravated the psychological plight of the orphaned children. One 12-year old orphan met during the study said she was contemplating running away from her adopted home as her extended family members were abusing her. In response to the question of how his life was like after the death of his parents, another orphan responded "*Ndinogara ndichishushikana pahupenyu hwangu, handizivi zvekuita*" meaning '*I'm always depressed about my life situation and I don't know what to do*'. In 30 (81.1%) of the orphan cases interviewed, no efforts had been made to help children cope with the loss of their parents, or

at least try to explain what illness had taken their parents. Therefore, the combination of material lack, psychological pressures of growing without parental guidance and general sub-standard treatment by relatives resulted in depression among orphans in this particular community, as shown by results from the Child Depression Assessment, disaggregated by sex as in the tables below.

		ORPHANHOOD STATUS				Totals
		Not Orphaned	Mother Late	Father Late	Double Orphaned	
Depression Assessment	Depressed	4	4	3	11	22
	Not Depressed	0	0	0	2	2
Totals		4	4	3	13	24

Table 3a: Depression Assessment Results for the male OVC interviewed in Hatcliffe Extension

		ORPHANHOOD STATUS				Totals
		Not Orphaned	Mother Late	Father Late	Double Orphaned	
Depression Assessment	Depressed	3	4	5	8	20
	Not Depressed	6	0	0	0	6
Totals		9	4	5	8	26

Table 3b: Depression Assessment Results for the female OVC interviewed in Hatcliffe Extension

As shown in the tables above, it was apparent from the results of the Depression Assessment Scale that double-orphans (both male and female) had the worst psychological pressures compared with other categories of orphans, accounting for a total of 19 (45.2%) of the 42 depressed child cases in the assessment. In the same group of double orphans, the males seemed to be more psychologically affected than their female counterparts, as noted in 11 males scoring as being depressed compared to 8 females.

It was also noteworthy that a small number (2 children) in the double orphans category did not score as depressed, and these were both male. This could be sign of some of the children somehow managing to cope with their predicaments and so resiliently move on with their lives. While there was an equal number of depressed orphans who had lost either parent as shown in the table above, female children who had lost their fathers appeared to have more depression (5) compared to their male counterparts who had also lost their fathers (3). Results in the study also indicated that not only was depression just in orphaned children, but also even in those who had both parents alive, as indicated by a total of 7 male and female children in the sample who were in the 'Not Orphaned' category scoring as depressed. This could have been so because of the sub-optimal living conditions in the slum i.e. the poverty, inadequate housing, high disease prevalence etc which in turn were causing depression in children with parents as well.

Consequently, due to the immense psychological pressures brought about by orphanhood, some of the children were reportedly taking up delinquent behaviour involving petty crimes, alcohol and drug abuse among the older orphans. Some of the children, particularly school-going age, were reportedly adopting violent and angry behaviours like bullying others in school, while others were withdrawn and not effectively participating in learning processes.

4.5 Knowledge, Attitudes, Practices and Behaviour towards Sexuality among Reproductive Age-Groups

4.5.1 General Perceptions on Condom Use and safe Sexual Behaviour

With regards to their perceptions on condoms, 71 (69.6%) of the KAPB survey respondents felt that condoms were very useful in prevention of unwanted pregnancy and STIs, including HIV and AIDS. In all the responses however, condoms were noted as not being 100% safe.

The remaining 31 (30.4%) respondents however felt that condoms were actually promoting casual sex and promiscuity in many people, especially among the youth, and this general feeling was also very prevalent among community leaders in the key informant interviews.

While programmes on HIV and AIDS awareness building were acknowledged to be contributing significantly to general increase in knowledge levels on the pandemic in the informal settlement, ignorance was said to still have been an issue of concern especially in the younger generations. Many myths on condom use still prevailed, for example that the condom would reduce sexual pleasure and also that HIV could penetrate through the pores of condoms. There was also insufficient knowledge on correct and consistent use of condoms, especially among the women, as was shown by the CUSE scale result illustrated in the graph below:

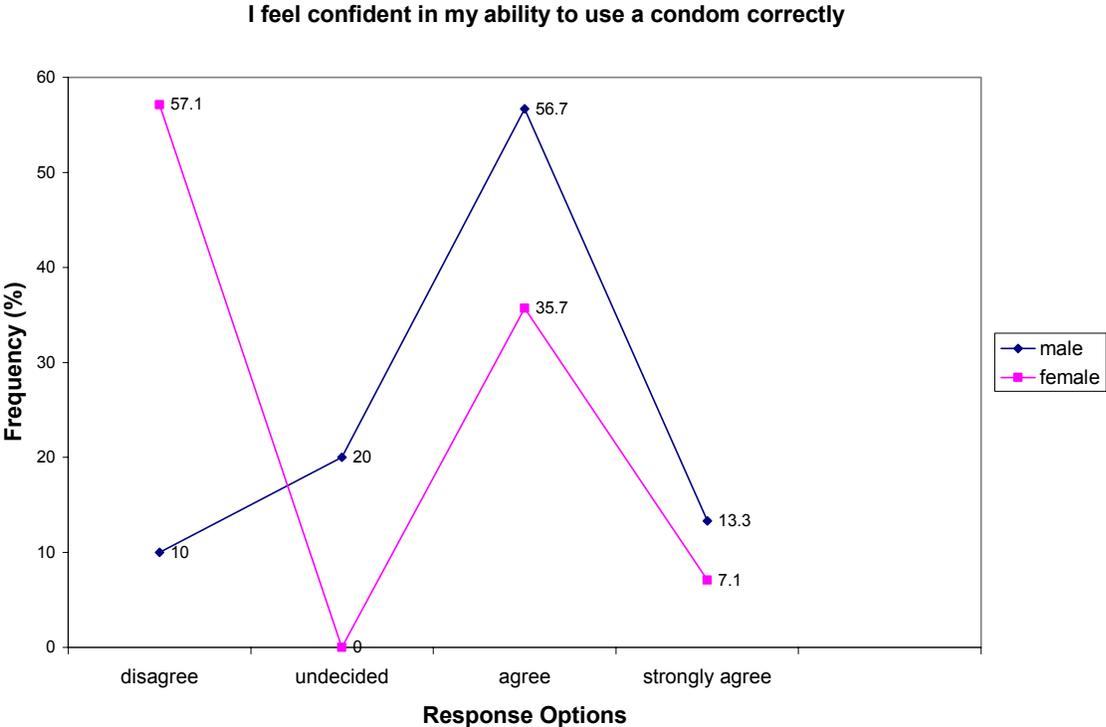


Figure 9: Graph of Responses to the Question of Correct Condom Use

The results indicated an overwhelming disparity in correct condom use between the male and female respondents, as evidenced by 57.1% (24) of the females disagreeing with the notion that they were confident in condom use compared to 10% (6) of the males. Such scenario was typified by the example of one young woman in the FGD with women who said she actually used an average of 4 condoms at a time as a way of protecting herself. Of course she was oblivious to the fact that friction during intercourse could easily result in breaking of the condoms, or they would slip and she could still be infected. The elderly also lamented that many of the people using condoms did not know how to safely dispose of them after use. As a result, used condoms were being thrown everywhere in the community and children were picking them up and blowing them as balloons.

Some young males within the community particularly regarded some of their colleagues who had numerous girlfriends and sexual relationships as heroes, probably not taking into cognizance the risks of HIV infection that such behaviour entailed. The youth mainly lamented that NGO programmes in the area mainly focused on food aid, in the process sidelining youth awareness on various aspects of HIV and AIDS. It generally emerged in focus groups that sex had for long become a survival strategy in the community, and so it would then be ideal for people to be empowered to protect themselves through capacitation on correct and consistent condom use.

It was also noted how many young people, especially the women had developed an element of fatalism i.e. hopelessness with regards to the pandemic. Indications were clear that bread and butter issues (that is food and money) preceded the fear of infection with HIV that could kill after a few years when starvation could kill in a few days. As mentioned by one respondent during a focus group discussion, many people had

adopted the attitude of saying “*kusiri kufa ndekupi?*” meaning either way poverty or HIV and AIDS would kill them, so taking risk as a survival strategy was part of the lifestyle.

4.5.2 Perceptions on VCT

Voluntary Counseling and Testing (VCT) was generally highly regarded in the settlement, and from the KAPB survey, 64 (62.7%) of the respondents affirmed that it was important for people to know their HIV status so that they could plan for the future. Ironically however, only 12 (11.8%) of the respondents had been tested, and the cited reasons for many being tested was that they could not afford to go into Harare city centre just to get tested because of the high cost of transport. Even if they would manage to go to the city centre, the respondents mentioned that they would not have any time to visit VCT centres since they would primarily be looking for means of survival through buying and selling of farm produce as well as second-hand clothes among other goods. It was also noted from the survey that there was a general fear among the respondents that if one went to get tested and was found to be positive, they would suddenly become ill or start to lose hope in life, even to the extent of committing suicide. The scenario was however different when it came to people who were already ill or suspected that their partners were suffering from or had died of AIDS-related illnesses. As emphasized by key informants from the WAAC and DAAC, VCT had become an incentive in this particular group since people officially recognized to be living with HIV and AIDS were offered extra support in terms of food aid and medication as well as support for their children to go to school.

4.5.3 Willful Transmission of HIV

Cases were noted from the focus groups of people willfully transmitting HIV to innocent victims. One story was told of a man who raped his 12-year old daughter knowing fully well that he was HIV positive, while there were cases of infected people who did not want to ‘die alone’, so would end up infecting others willfully. A few women on ARVs in the community were also well known for inviting younger men to do chores for them at their houses, invite them for a meal afterwards as a way of ‘thanking’ them, then subsequently enticing the young men into sleeping with them. This was also noted as a possible negative externality brought about by Anti-Retroviral Therapy, in that people who would have significantly recovered through the use of ARVs could suddenly think they were well again and so could go back to their old ways e.g. going to bars, having multiple partners etc

4.6 Factors Inhibiting Effective Response to HIV and AIDS in the Settlement

4.6.1 Programmatic Interventions: Challenges and Bottlenecks

There were five general categories of programmes that were being run by the numerous NGOs as well as a government ministry working in the informal settlement. The first was on food relief that targeted everyone in the community, and this constituted the main line of programming. The next category was that of medical support for the community (provided in collaboration by the Ministry of Health and NGOs), as well as medical and nutrition support specifically for People Living with HIV and AIDS (PLWHA), which was being run by NGOs. There were also programmes on school fees and other forms of material support for OVCs as well as general HIV and AIDS prevention education programmes. One of the organizations ran an ARV programme in which they referred patients to their own specialists who did the VCT, CD-4 counts and subsequently put the patients on ART. Faith-based Organizations were also coming up with spiritually-based programmes promoting abstinence and faithfulness in the community.

Locally-based churches, with the aid of their parent churches in the city, were spearheading care and support programmes for the congregation members as well for other PLWHA in general. Their programmes on food aid were also helping improve disclosure as beneficiaries of food assistance meant for PLWHA would need to have been tested and certified HIV positive. Another church in the capital had also initiated a programme to build houses for members of its denomination living in Hatcliffe Extension. It emerged in discussions with a key informant from the local WAAC that effective HIV and AIDS programming was being inhibited in sections of the community belonging to the Islamic faith. The religion was said not to interact with other religions because of their beliefs, therefore its members would not participate in faith-based programmes on HIV and AIDS that were being organized by the Ward AIDS Action Committee. This was stifling a collaborative response strategy to the pandemic among the various religions in the community. While the local WAAC had resolved to initiate programmes that would exclusively be for members of the Islamic faith, resources were proving to be the main limiting factor.

The GoZ through the National AIDS Council was also anticipating scaling up ARV programmes in the area encompassing the informal settlement. Like many other NGO-based activities, organizations working in Hatcliffe Extension lamented marked reduction in funding for programming, which negatively impacted on sustainability of their activities. Cutting of certain lines of programming were typical within these organizations as they sought to deal with narrower budgets. A key informant from one of the organizations raised a concern that organizations were failing to capacitate the community in terms of its preparedness to continue with various activities after the inevitable pull-out of the organizations. A case was highlighted of one organization that had intended on assisting the community slowly build houses, but then decided to pull out just as the project was gaining momentum and the people were not pleased. It then emerged that the organization had pulled out their resources strictly on security grounds, but the

community had not been informed or at least capacitated on means to pick up the project after the organization's pull-out.

Political interference was also highlighted as a challenge in the organizations' work as it impeded on progress with the clashing of the development and political committee structures that were found in the community, with the latter interfering in the activities of the former. General suspicion between NGOs and government was also mentioned as not making developmental work any easier in the area. Key informants from the organizations generally singled out poverty as the main driver of the HIV and AIDS pandemic in the informal settlement as people especially women, took up risky sexual behaviours e.g. transactional sex, inter-generational sexual relationships in order to try and make ends meet. It was a consensus amongst the organizations that the cycle of poverty had to be broken down before sustainable mitigation of the HIV and AIDS pandemic could be spoken of in the area.

The 'closed' (isolated) nature of the community also brought in complications with regards to effecting the protection of children and vulnerable women from sexual abuse, one of the factors highlighted as fuelling the spread of the pandemic in the community. As mentioned by a key informant from one of the organizations working in the area, cases of crime, abortions, as well as violence against women and girl-children would often go unreported and in many cases would die natural deaths within the confines of the community. There seemed to be no direct link between the community and the police, therefore programmes to protect these vulnerable groups were therefore said not to be fully effective considering that there was inadequate reinforcement with regards to support from the police. Even suggestion boxes where people could anonymously report cases of abuse or other crimes were also not present, and this further compromised channels for accessing police protection in the community.

4.6.2 Coordination of the HIV and AIDS Response

Under the premise of the ‘Three Ones’ principle of a **One** agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners, **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate as well as One agreed country-level Monitoring and Evaluation System, NAC has responsibility of coordinating the multisectoral response strategy to the pandemic in Zimbabwe. However, the study established a great challenge in terms of the partaking of this role by the National AIDS Council (NAC). Many of the NGOs and FBOs working in the area were basically doing the same kinds of work and beneficiary registers in most cases indicated names of people appearing more than once for the same kind of assistance under different NGO programmes e.g. in school fees assistance lists for orphans, home-based care kits provisions, food aid to people living with HIV and AIDS etc. It was established from discussions that the community tended to have their names registered with as many organizations offering any form of assistance in the community as they could so that they could cumulatively get more aid through receiving many ‘small’ hand-outs from individual organizations. Some parents even had the guts to register their children as orphans to get extra food and non-food supplies from NGOs, and this was mainly so because there was so much duplication and confusion as to who was dealing with which beneficiaries amongst the organizations themselves, hence making it hard to check against fake claims and fraud.

Where there had been capacity building programmes and training related to effectively responding to the pandemic, the same people who got either training or capacitation from one organization were found to be benefiting in exactly the same manner in a couple of other organizations because of the lack of a systematic co-ordination mechanism to these processes. Key informants from NAC acknowledged these

problems and they mentioned that the organization was undertaking efforts to enhance stronger interagency coordination and collaboration as a means of putting a check on duplication as well as the fragmentation of resources in the fight against the pandemic. Gaps were also noted in the lack of an audit system which sought to establish which organization was doing exactly what as well as how their efforts were complementing other organizations' efforts as far as response to the pandemic was concerned in the area.

4.6.3 Political Interference in Programming

The unfavourable political landscape within the informal settlement also emerged to be another major issue of concern as far as development in the area was concerned. Due to increased vulnerability induced by poverty and general lack in the community, politicians had for a while been taking advantage of the area as they viewed the settlement as an area for garnering easy votes. Community leadership was therefore split along political lines and as a result there was often too much political interference in the running of developmental programmes in the area. The area's developmental committee also had political people and the resultant clashes also slowed down developmental processes. A case was pointed out of a politically-oriented member of the local developmental committee who interfered with an income-generating project as she intended to have her relatives to solely benefit from the proceeds of that project which was running a pay-phone facility. Corruption and nepotism were also major challenges as there were reported cases of abuse of authority and responsibility by some of the leadership in allocating resources, food aid etc to their relatives and associates at the expense of the very needy and vulnerable members of the community. Some people fraudulently got their names onto lists of PLWHA so that they could also get assistance meant for the AIDS patients.

In a typical case of abuse of responsibility, one male food distributor was said to have been asking for sexual favours from beneficiaries so that they could be prioritized in distribution of food commodities.

4.6.4 Dependency Syndrome

Dependency syndrome was reported to have become so rampant in this particular community that the majority of people could not get themselves to do any self-help activities. As pointed out by key informants from some of the development agencies working in the area, provision of food aid, clothing, free medication and school fees assistance for some of the families had virtually turned the settlement into a community of people who no longer wanted to work for themselves, but just receive. Previous efforts to initiate income-generating projects had dismally failed as a result of no apparent effort being put towards their success by the intended beneficiaries. Cases were noted of some groups of individuals who had misappropriated funds meant to be used as capital in income-generating activities. During the course of the study, questions as to what further assistance people wanted were often met with the response implying the need for more donors to bring both food and non-food commodities into the area. While local leadership realized the need for projects which would empower people at the grassroots level, the main challenge was the community buy-in into such activities.

4.6.5 The Impacts of Operation Restore Order/ Murambatsvina

The Government of Zimbabwe's clean-up exercise code-named Operation Restore Order/*Murambatsvina*, which was meant to rid urban areas of informal settlements as well as informal trading markets and stalls (alleged to have been fuelling crime and illegal foreign currency dealing) was noted to have had a drawback impact in the fight against HIV and AIDS in Hatcliffe Extension. Programmes on prevention, care and support as well as treatment were disrupted upon the displacement of people during the exercise.

One FBO reported that it was facilitating the getting of ARVs by 105 AIDS patients in the community, and with the displacements, they did not know where some of their clients had gone off to, and imminently had to discontinue the programme. Another programme offering pre-school facilities to at least 120 OVCs was also disrupted and the pre-school had to be closed because of the Operation Restore Order/*Murambatsvina* displacements.

A key informant from one of the organizations working in the area also highlighted that they were getting phone-calls from parents and guardians whose children had been benefiting from their school fees assistance programmes who still wanted assistance, but unfortunately had been displaced to their rural areas. The Caledonia Farm transitional camp where people were being taken to during the exercise also was reported to have been a high-risk area in terms of spread of HIV infection. Transactional sex with commercial sex workers who had been rounded up from city center brothels was said to be rampant. One young man who had been at Caledonia had this to say about the place during an interview:

“Haa, mukoma, manje kuCaledonia ndoo kwanga kuine morari manje” (loosely translated; *my brother, there was a lot of fun at Caledonia*).

Upon probing on what fun there was at the transition camp, the young man then disclosed how the sex workers could even be engaged for sex for little or no money at all as people sought to entertain themselves in that particularly distressing environment.

When the inhabitants of Hatcliffe Extension were allowed to return to places within their settlement allocated to them as stands, the conditions were even worse in terms of social amenities like safe drinking water, access to medication and safe toilet facilities (people were improvising by digging shallow pit latrines which were not taking time to fill up). Most of the organizations working in the area however resumed their operations with regards to food and non-food assistance, as well as putting up efforts to re-establish social capital and networks for the community to effectively respond to the pandemic. Support groups for PLWHA were re-established and registers for OVCs began to be updated so that assistance could be directed to areas of greatest need.

CHAPTER 5

5.0 DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0.1 Introduction

This final chapter critically analyses the findings from the research, and attempts to link them with the study questions and objectives. It discusses in-depth what came out of the study and seeks to establish correlation between the empirical evidence from the findings with the theoretical bases of the study. The chapter also gives the conclusions to the study of the challenges of HIV and AIDS in the Hatcliffe Extension informal settlement taking cognizance of the findings and their critical analysis in the discussion. The last part is where the chapter gives recommendations to various stakeholders in the development arena with regards to ways that could further strengthen effective responses against HIV and AIDS in informal settlements.

5.1 The Complex Web of Risk and Vulnerability

The findings of the study generally show the high risk nature of informal settlements with regards to spread of HIV due to human and income poverty as the main contributory factors. Although all stories could not be told and heard because of logistical constraints, including the Operation Restore Order/*Murambatsvina* clean-up exercise, obvious trends could be picked from the data collected in the study. While poverty, unemployment and lack generally led to social ills like crime among the males in and around the community, women were shown to be the worse affected and more vulnerable. Women were particularly exposed as being highly vulnerable to HIV infection due to socio-economic disempowerment, violence as well as cultural stereotypes making them subservient and imminently insignificant decision-makers with regards to sexuality issues. As generally shown by the Condom Use Self Efficacy scale results, women found it difficult to negotiate for safer sex and this is unfortunate in this

era of HIV and AIDS. A careful analysis of the sex networking web for Hatcliffe Extension also further confirmed how the feminization of poverty had further aggravated the risk and vulnerability of women to the HIV and AIDS pandemic. Clearly, therefore, behaviour change-based HIV and AIDS programming without socio-economic empowerment would be almost irrelevant to such women as are found in informal settlements considering that they have such limited sexual freedoms and livelihood alternatives. Not only would prevention interventions be critical to curb the supply side of commercial sex (i.e. the impoverished women depending on sex as a survival strategy), it would also be important to have programmes targeting the demand side (i.e. the relatively wealthier men in and around the community who paid for transactional sex) in order to ensure a more holistic and effective HIV and AIDS prevention strategy. The impacts of the pandemic in the informal settlement apparently had gender dynamics which would need to be taken cognizant of in design and implementation of intervention strategies. While the youth were seen as a high risk group with regards to HIV infection, in this group also lays a window of opportunity with regards to the fight against the pandemic. Sustainable prevention education and behaviour change programmes in this age group would indeed go a long way in terms of reducing new infections as the youth enter into the peak of sexual activity.

5.1.1 The Plight of Orphans and other Vulnerable Children

The plight of children in the particular community would be better discussed in terms of a rights-based perspective. It is clear that children's living conditions in the informal settlement fell far below standards conducive for child growth and development. Principle 2 of the United Nations General Assembly Declaration of the Rights of the Child of November 1959 (www.unhchr.ch , 05/01/2006) states that "the child shall enjoy special protection and shall be given opportunities and facilities..... to enable him/her to develop physically, mentally, morally, spiritually and socially." This was definitely found not to be the case in Hatcliffe Extension, as neglect of children by guardians gone to look for employment,

sexual abuse of children as well as cases of child labour violated this particular clause of the Declaration. The prevalence of child sexual abuse also violates the African Charter on the Rights and Welfare of the Child Article 16 and 27 while the incidences of child labour violates Article 15 of the same Charter (OAU, 1999:5-8)

The conditions in the informal settlement without doubt tended to increase children's risk and vulnerability to HIV infection through various forms of sexual exploitation. With such complex levels of sex networking as described in the previous chapter, the situation is not made any better. A failure of proper child growth and development would then go on to have a ripple effect as they grow to become uneducated and abused adults who would also likely become abusive themselves. It means that the cycle of HIV and AIDS amongst young adults would imminently be difficult to break. As long as the children continue to be exposed to infection and there are no deliberate efforts to ensure child protection, it would always be a difficult task to reduce incidences of new infections in such informal settlements. Orphanhood also was shown to present extra risk to children, especially the girl-children as they would end up in intergenerational and transactional sexual relationships as a survival strategy. The psychological needs of such children were also evidently not being met, and there is great danger that the children would as a result indulge in deviant behaviours including crime and commercial sex, factors again increasing risk and spread of HIV in the informal settlement.

As was evident from the child HIV and AIDS cases in the study, continued ignorance of children in anti-retroviral treatment issues would only worsen the burden of care on the already impoverished community devoid of social safety nets. It means then that resources for programmatic interventions in the area would continue to be channeled towards material care and support, at the expense of other HIV and AIDS

response facets including prevention education or socioeconomic empowerment through income-generating projects.

5.1.2 Co-ordination of the HIV and AIDS response

The National AIDS Council has a clear mandate to mobilize, co-ordinate, facilitate and monitor an expanded national multi-sectoral response strategy to the pandemic in the country under the One HIV and AIDS Strategy, One Co-ordination Mechanism as well as One Monitoring and Evaluation Mechanism (Three Ones) Principle (NAC, 2004). However, as evidenced in this particular study, such role was not apparent at the grassroots level in Hatcliffe Extension, hence evidence of duplication and no clear direction in the various response mechanisms by organizations working in the area. This was most probably emanating from weak institutional capacity in NAC itself with regards to effective co-ordination of the larger response strategy at national level. It would only then imply that at the community levels, implementation of a co-ordination framework would be even more complicated if mechanisms were failing at the national level. Such a scenario is without doubt unfortunate especially when it comes to responding to the pandemic in high-risk areas like informal settlements. A weaker response strategy against HIV and AIDS in such areas would continue to reverse gains made against the pandemic at a national scale since the informal settlements could end up becoming focal points of HIV infection and spread due to sex networking.

While NAC might want to justify its presence by implementing activities (e.g. OVC support, food assistance) at DAAC and WAAC levels (perhaps so that the public could see where their AIDS Levy is going), the role of co-ordination definitely still has glaring gaps. If the scenario does not improve, resource losses and inefficiencies are likely to perpetuate due to duplication of programming by organizations partaking of HIV and AIDS activities, hence hampering effective response to the pandemic.

It goes without saying that worst case scenarios of the pandemic, including informal settlements would continue to be affected by these inefficiencies. It can therefore never be over-emphasized that the coordination of the response strategy would play an important role in giving focus and direction to all stakeholders involved in the fight against the pandemic. While the integration of political people into DAAC and WAAC structures might help in promotion of political commitment to the response strategy, there is a danger of certain attributes of politics, including corruption, nepotism and clashes for leadership roles negatively filtering into and so destabilizing the response framework to the pandemic, as the study gave indication to. It would then be ideal to have a non-political set-up to NAC structures at the grassroots levels.

5.1.3 Quality of Assistance, Welfarism versus Empowerment

A lot of concern was raised during the study about both food and non-food assistance meant for those infected and affected by HIV and AIDS not reaching the intended beneficiaries. This raises questions on how effective humanitarian organizations seeking to alleviate the plight of the slum dwellers qualitatively assess the progression of their programmes, or perhaps they would just focus on how much quantities they would have given out to the communities. It goes without saying then that for as long as measures are not being put in place to make sure that intended beneficiaries receive assistance, mitigation of the household and community level impacts of the pandemic would continue to be elusive. The culture of welfarism that NGOs working with the poor seem to adopt is not sustainable, because food handouts do not empower people to live beyond the day the donated food finishes off. Even attainment of the Millennium Development Goal 1 on poverty eradication would not be a reality for as long as poor people are only living on humanitarian assistance. A paradigm shift would therefore be needed towards projects that work more or less on an empowerment basis.

5.1.4 Implications of Social Re-engineering

While it may be acknowledged that cultural intermixing as was found to exist in Hatcliffe Extension could be beneficial in terms of inter-cultural learning, it might just also bring with it some negative externalities. Jackson (2002) highlights on certain cultural systems that uphold the belief that sleeping with a virgin could cure one of HIV and AIDS among other illnesses. It probably could have been because of cultural intermixing that such beliefs would have found way into the Hatcliffe Extension community, hence high cases of child sexual abuse as people sought to be ‘cleansed’ from HIV and AIDS. The issue of culture, as it relates to widow inheritance and polygyny also links with socio-economic disempowerment of women, which has already been elaborated on as increasing women’s risk and vulnerability to HIV infection. It would therefore become very difficult to challenge socio-cultural practices and stereotypes increasing HIV infection and spread among particular groups, especially the women, because of the inter-cultural mix in the population in slums.

5.1.5 Operation Restore Order/Murambatsvina

While the principle behind Operation Restore Order/Murambatsvina might have been noble, inadequate planning for this exercise unfortunately made socio-economic predicament of poor people in slums like Hatcliffe Extension worse than before. The implications of the exercise only meant a more complexing of the cycle of poverty as people lost means of survival and this brings to doubt whether political will is actually present to eradicate poverty as underscored by Millennium Development Goal (MDG) one, which paradoxically the nation has prioritized alongside MDGs three and six⁷. Even the disruption of HIV and AIDS programmes due to the exercise also brings into question the presence of real commitment which transcends political rhetoric to combat the HIV and AIDS pandemic.

⁷ Millennium Development Goal three is on Gender equality and empowerment of women, while number six is on Combating HIV and AIDS, Malaria and other diseases

The implications of the clean-up exercise which saw people from the informal settlement being moved back and forth also casts shadows on whether there is real policy on informal settlements in the country. It could be likely that since the slum phenomenon has not been as prevalent in Zimbabwe compared with other developing countries in Africa and on other continents, the issue could be a policy blind spot and so not being given much attention. With the declining socio-economic environment however, rapid urbanization is inevitable and so it would only be a matter of time before slums mushroom again in peri-urban areas. Careful consideration and planning would need to be done at government level to ensure that the phenomenon of informal settlements receives the appropriate attention it deserves.

5.1.6 Importance of Prevention and Awareness Programmes

Prevention and awareness-raising are key components of any response strategy to HIV and AIDS, therefore it would be very unfortunate if issues like VCT, ART and proper condom use are not raised or are inadequately addressed in awareness campaigns. Scenarios of lack of confidence in condom use, skepticism over VCT, proper use and meaning of ART which were established from the findings could be minimized if efforts in awareness-raising were scaled up. Proper counseling would also be critical in the reduction of willful transmission of HIV in informal settlements.

Overallly the empirical evidence from the study went on to confirm the issues that were brought about by the major theoretical basis of the research i.e. the Theory of Culture of Poverty. Results from the study clearly supported the supposition by the Culture of Poverty theory that slum settlements are ‘closed’ and ‘inward-looking’, as evidenced by the many sexual abuse cases among other crimes dying natural deaths within the communities without being reported. Fatalism and helplessness, issues also highlighted in the theory were expressly brought out during the study especially among the females as they would expose themselves to HIV infection through multiple sexual relationships after losing hope of finding any other

means of sustainable survival. Because of hopelessness, alcohol and drug abuse were also high in this community, factors also further exposing people to risky sexual behaviours imminently resulting in HIV infection. The study also brought out clearly that where the 'culture of poverty' exists, such an area is vulnerable to manipulation by politicians as they would seek to take advantage of the desperate people to fulfill their own political ends. As evidenced in the study of Hatcliffe Extension, there were indeed too much political sensitivity and strong political structures in the community, which inevitably ended up interfering with developmental programming. The divisions along political lines within the community were also disrupting the building of proper social networks important in effectively responding to challenges in the community like HIV and AIDS, child abuse as well as poverty.

5.2 Conclusions and Recommendations

The study expressly affirmed the two-way interlinkage between HIV and AIDS and poverty, the latter which was due to a combination of socio-economic, socio-political as well as socio-cultural factors. On one end of the inter-relationship, lack of income for both food and non-food basics essentially was forcing people, mainly the women to engage in risky sexual behaviour as a survival strategy. This was resulting in the complex web of risk and vulnerability that needed to be broken if progress could be made in combating the pandemic in such areas as Hatcliffe Extension. Sexual, as well as psychological abuse and violence against women and children was also established to be fuelling the spread of HIV amongst the most vulnerable in the community who did not have the capacity to protect themselves. Poverty was also realized to be causing hopelessness and fatalism in the community, thereby leading to anti-social behaviours like crime, alcohol as well as substance abuse and in the process increasing chances of risky sexual behaviours fuelling HIV infection and spread. It was also realized that there was a need to reverse the mindset of dependency that had set into the people to the point of just waiting for food and non-food

assistance from relief organizations working in the area, without wanting to work for their own selves. It was also concluded that there was a need to improve the effectiveness of the HIV and AIDS response in the area which was being hampered by lack of a proper co-ordination mechanism, hence prevalence of duplication and confusion in activities. The study also concluded that the issue of informal settlements was not receiving enough policy attention, yet these were areas highly vulnerable and with so much risk of HIV spread that could even to a wide scale reverse gains made in the fight against the pandemic in the country.

The study then went on to recommend action points for the alleviation of the impacts of HIV and AIDS in informal settlements and they are as given below:

- A need was seen for the medium to long-term conceptualization by NGOs working in informal settlements of projects that would socio-economically empower the people as well as provide them with sustainable alternative livelihood strategies. This was seen as critical especially with regards to breaking the cycles of poverty and dependency inherent in such communities.
- The study also saw it as imperative that development organizations working in informal settlements work towards programmes ensuring gender equality and empowerment of women through income-generating projects. This was seen as a vital component in poverty alleviation as well as reduction of risk and vulnerability to HIV infection among women.
- Government needs to show stronger commitment towards attaining the MDGs and the alleviation of human poverty in the country. There is need to continuously mainstream the MDGs in budgetary allocations and special focus also needs to be put on areas like informal settlements as they have very poor conditions for human habitation and development.
- As emphasized in the review of literature, slums are inevitable phenomena in the light of rapid urbanization and decline in socio-economic situation. It would be most ideal to work more towards

upgrading of slums in terms of social amenities and making them more habitable as lasting solutions to housing crises are being sought after.

- Commitments towards rebuilding exercises like Operation Restore Order/ *Murambatsvina* would in the future need to be properly budgeted and planned for so as to avert unnecessary human suffering as well as destabilization of developmental programmes.
- It would also be essential for the Government of Zimbabwe to ensure that as ART programmes continue to gain momentum in the country, informal settlements also be reached out as they are highly risky and vulnerable areas in terms of HIV infection and spread.
- It was realized that despite the political sensitivity of the informal settlement, FBOs generally had the most acceptability at grassroots levels in the area and were trusted across political divides. This is an opportunity for development agencies, including government and donors wishing to support HIV and AIDS programmes in such settlements to forge partnerships with FBOs for enhanced effectiveness at grassroots level.
- It is clear that assistance for PLWHA was not enough; therefore there would be a need for NGOs working in such settlements as Hatcliffe to support income-generating projects for people living with HIV and AIDS. This would assist in that they would not continue being reliant on food aid and burdening their already impoverished families and community as they would now be able to partly provide for themselves.
- In order to avoid the confusion over roles and responsibilities of organizations responding to the pandemic in the area, which subsequently led to duplication of activities, it is the study's recommendation that NAC's coordination programming be informed by outcome-based and results-based management methodologies. This would help to ensure that the roles of individual players are clearly defined, resources are more efficiently used and duplication kept in check. It would then be

critical that the Government of Zimbabwe among other funding partners including the UN agencies offer capacity building support to NAC so as to enhance its effectiveness in coordination of the HIV and AIDS response strategy in the country.

- The study also demonstrated that little consideration was being put into helping children cope with the psycho-social challenges of dealing with loss of parents in the informal settlement. There would therefore be need for activities on spiritual and psychosocial support for OVCs as a means of preparing them for life without their parents.
- It would also be imperative for programmes in condom promotion and social marketing to be enhanced in informal settlements since it was apparent from the Hatcliffe Extension study that sex was a survival strategy in the area. Therefore it was perceived as better off if people, especially the women, could protect themselves using condoms and in the process prevent the further spread of HIV and AIDS.
- Another challenge that emerged from the study was the closed nature of slum communities. As a result various crimes, acts of violence among other anti-social behaviours would happen in the community and these would go unchecked. More interaction between the police and such communities would be important, especially the setting up of reporting procedures e.g. police suggestion boxes for the reporting of crimes and abuse cases.
- The study showed the need for HIV and AIDS programming by NGOs and their partners in the informal settlement to mainstream youth as this particular constituency had been sidelined by activities, yet it had high risk of infection and also presented the window of opportunity for the combating of HIV and AIDS in the area.
- Cycles of human poverty were without doubt confirmed to be the main factors fuelling the HIV and AIDS pandemic in informal settlements. It would therefore be imperative that central government

maintains momentum in trying to find solutions to the currently declining macro-economic situation in the country as a way of reducing risk and vulnerability to infection amongst the poor.

- A need was also realized for programmes aimed at reducing gender-based violence as it was another factor that was increasing the vulnerability of women to HIV infection.
- It would be critical for government to come up with a long-term policy and practice positions for minimizing the mushrooming of informal settlements which were shown to be areas of high risk and vulnerability to HIV infection and spread. Taking advantage of the land redistribution exercise to allocate land for housing would be a good starting point.
- The challenge of providing housing to thousands of homeless people in the country would not be overcome by individual efforts on the part of government, private sector or NGOs alone. There is therefore need for a well-coordinated platform putting the three partners together so that lasting solutions could be mapped and implemented.

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ANNEX 1

Sample size determination

In determining the size of the most representative sample size with minimized variance i.e. sample most representing the population, a few assumptions were made, as below;

- The degree of accuracy in the study would be assumed at 0.05. This means that deviations of sample estimated from the true population would only be considered accurate if the significance was 5% or better.
- A confidence interval of 95% was also assumed. This would be the degree to which the study would be confident of the sample estimates. The customary 95% confidence interval typical of social science studies was assumed.
- Minimum differences. The assumption would be that there would be some group differences in the sample, and to measure those differences, the significance of the minimum difference would be emphasized. The implication here would be that the smaller the difference expected, the larger the sample size.

Given these assumptions, the below formula would then be used to determine sample size:

$$N = Z^2 pq/d^2$$

N: the desired sample size

z²: the standard normal deviate usually set at 1.96 which corresponds to 95% confidence interval

p: the proportion in the target population estimated to have a particular characteristic

q: 1.0- p

d²: the degree of accuracy desired. This would be 0.05 in this particular study (UNICEF, 2002)

The variables for the study were:

Z: 1.96

p :0.45 (derived from estimates of adults in the population)

q: 0.55

d: 0.05

The sample size for this determination (N) was therefore = $(1.96)^2 \times (0.45) \times (0.55) / (0.05)^2$

N= 373

ANNEX 2: Research Instruments

ANNES 2a: Hatcliffe Extension Study_2005 Survey - (Adolescents and Adults) Questionnaire

Interviewer:

Date:

Age of Respondent: _____

Sex: _____

1. What are some of the key health problems you are facing in this community?
2. What could be causing these problems
3. What is your understanding of HIV and AIDS?
4. Do you consider HIV and AIDS to be a serious problem in this are? Y/N _____
5. If yes, how has it manifested itself?
6. Which groups of people do you consider to be most vulnerable to infection, and why?
7. From your own perspective, what could be fuelling the spread of HIV and AIDS in your area?
Explain
8. As young people/adults living in this community, what measures have you taken to help in preventing the spread of HIV and AIDS?
9. Are there4 any programmes aimed at prevention and awareness that you are a part of in your community?
10. Who are the partners that you are working with in these programmes? **(probe for government, NGO programmes in the area what they are specifically tackling)**
11. In your view, have these programmes been effective and what can be done to improve them?
12. What are your perceptions on condom use in general?

13. The Condom Use Self-Efficacy Scale

These questions ask about your own feelings about using condoms in specific situations. Please respond by ticking or selecting the appropriate response for each even if you are not sexually active or have never used (or had a partner who used) condoms. In such cases indicate how you would feel in such a situation.

Strongly Disagree Undecided Agree Strongly
Disagree Agree

I feel confident I could purchase
condoms without feeling embarrassed

I feel confident I could remember
to carry a condom with me should I need one

I feel confident in my ability to discuss
condom usage with any partner I might have

I feel confident in my ability to suggest using condoms
with a new partner

I feel confident I could suggest using a condom without
my partner feeling 'diseased'

If I were to suggest using a condom to a partner, I would feel afraid
she would reject me

If I were unsure of my partner's feelings
about using condoms, I would not suggest using one

I feel confident in my ability to use a
condom correctly

I would feel comfortable discussing condom use with a potential
sexual partner before we ever had any sexual contact (e.g. hugging
caressing etc.)

I feel confident in my ability to persuade a partner to accept
using a condom when we have intercourse

13. What are your views on VCT?
14. Have you ever been tested before? Y/N_____. If no, would you like to get tested?
15. What are your views/comment on the following vis a vis your community:-
 - Polygyny
 - Small Houses
 - Intergenerational sex
 - People who willfully infect others with HIV
 - Anti-retroviral drugs
 - Traditional healers/doctors/faith healers who claim they can cure AIDS?
16. What in your opinion should be done to prevent the spread of HIV and AIDS in your community?

THANK YOU FOR YOUR TIME!

ANNEX 2b - Community Leaders' Interview Guide

1. What are the main problems that you are encountering in this community?
2. What has been causing these problems?
3. What is your understating of HIV and AIDS, and do you see it as a major problem in this community?
4. In your view what could be fuelling the spread of the HIV and AIDS pandemic?
5. What then should be done to prevent the further spread of AIDS, especially in this community?
6. What kind of open discussions are held to discuss HIV and AIDS in this community?
7. Are young people participating in these forums?
8. What are your views on condom use in general?
9. What are your views on condom use among the youth?
10. What are your views on faithfulness and multiple sex partners? (Probe on polygyny, extra-marital affairs, intergenerational sex)
11. Traditional aunts and uncles have played an important role in educating and counseling youth on sexuality, but this has since changed. In your opinion, who should be giving youth this information?
12. Are there any organizations that have been doing HIV and AIDS-related work in your community? What are these organizations?
13. How has been the reach of their programmes in this community?
14. As community leaders, what do you perceive as your role in HIV and AIDS prevention among the future generation?
15. As community leaders, how do you see your role as role models in HIV prevention?

ANNEX 2c: In-depth Interview Guide for PLWHA

1. How did you find out about your HIV status?
2. How did you react to this diagnosis? Who did you tell?
3. What have been your experiences living with HIV and AIDS? Any problems you have encountered? Who do you confide in?
4. How are people living with HIV and AIDS (PLWHA) treated? How are affected households with sick PLWHAs supported by community members?
5. Are there community initiatives to support PLWHAs? Elaborate on the type of support, is it treatment and care, spiritual and moral support, material support, income-generating support
6. Are there other external agencies that assist PLWHAs? What sort of support do they provide? How well do PLWHA participate in community development in general?
7. As PLWHAs, what role do you play in HIV and AIDS prevention, care and support, mitigation in the community?
8. In your view are youth heeding the HIV and AIDS prevention message in this community? Explain
9. What can be done to ensure that HIV and AIDS are effectively prevented especially among the youth?
10. In general, do you think there is behaviour change in the community?
11. Anything else you would wish to say pertaining to HIV and AIDS in this community?

ANNEX 2d: Key Informant Interview Guide – HIV and AIDS Programme Implementers

1. Name of organization/programme?
2. When did the organization start operating in the area?
3. Are the organization's current programmatic objectives the same as when it started? (If not, explain)
4. Can you briefly outline the activities the organization is involved in within this community?
5. What facilities are used for implementing these programmes e.g. health service delivery point, community-based centres, Community health personnel etc?
6. Does the organization train local programme personnel for implementation of its HIV and AIDS programmes?**(probe for type of training provided)**
7. Who are the target beneficiaries?
8. Who funds your programmes?
9. Can you briefly highlight on what have been your experiences in HIV and AIDS programming in this area?
10. In your opinion, what are the main challenges in addressing the HIV and AIDS pandemic in informal settlements?
11. How best can these challenges be overcome?
12. What challenges/bottlenecks/constraints does the organization meet in its implementation strategies?
13. How have these been addressed?
14. What lessons has the organization learnt in implementing its activities?
15. Does the organization collaborate/work with other services/programmes?
16. What are the organization's future plans in terms of expansion of programme activities?

ANNEX 2e: Hatcliffe Study_2005 - In-depth interview Guide for OVC

Age of Respondent _____

Sex of Respondent _____

Orphanhood Status _____

A. Psychological Aspects of Parent Loss (Non-Applicable for the control part of the sample)

1. How did you feel when your parents were ill/not well?
2. Were you in any way helping to look after your sick parent(s)? If yes, how were you helping?
3. Upon the passing away of your parent(s), did anything change in your lives? If yes, what were these changes?
4. How did you feel at the loss of your parent(s)?
5. Did anyone help you to cope psychologically with the loss of your parent(s)? (**Probe for any forms of spiritual and psycho-social support**)
6. Do you feel you would need any sort of psychological support to help you cope with your situation?

B. Child Depression Assessment Scale

For each of the following statements (**feelings**), respond by choosing one of the 3 alternatives i.e. **Yes, No** and **Sometimes**.

NO SOMETIMES YES

1. I am sad all the time
2. Nothing will ever work out for me
3. I do everything wrong
4. I am bad all the time
5. I am sure terrible things will happen to me
6. I hate myself
7. All bad things are my fault
8. Nothing is fun at all
9. I feel like crying everyday
10. Things bother me all the time
11. I do not want to be with people at all
12. I can not make up my mind about things
13. I look ugly

14. I have to push myself all the time to do my schoolwork
15. I have trouble sleeping all night
16. I am tired all the time
17. Most days I do not feel like eating
18. I worry about aches and pains all the time
19. I feel lonely all the time
20. I never have fun at school
21. I do not have many friends
22. I do badly in subjects I used to be good at
23. I can never be as good as others
24. I never do what I'm told
25. I get into fights all the time

ANNEX 2f: Hatcliffe Study_2005 - Discussion Guide with OVCs

- What are some of the problems that children like you (who have lost either one or both parents) face in their day-to-day lives?
- What sort of support would you think could help in alleviating these challenges?
- Are you getting any form of support from anyone to help you with your plight? What forms of support are you getting and from who?
- Is this help enough? Y/N_____. What else would you think still needs to be done to improve this support?
- What do you feel the community needs to do to support children who would have lost their parent(s) so that they have a better life?

ANNEX 3: Statement of Consent for the Respondents in the Study

Statement of Consent

My name is Charlton C. Tsodzo/..... and am a research student with the Institute of Development Studies, University of Zimbabwe .We are carrying out a research on the Challenges of the HIV and AIDS Pandemic in informal settlements, and we are case-studying your community, Hatcliffe Extension. The results from the study would hopefully be used in policy and programme design by various stakeholders ranging from government, NGOs among other partners to alleviate the plight of such areas as this one with regards to HIV and AIDS.

I was therefore asking for about 30-45 minutes of your time to go through the few questions I would like to ask you from a questionnaire. The information you give me would be anonymous, confidential and would not be attributed to you.

If you are in agreement, then you could give me confirmation in principle and we could proceed.

Thank you,